REVIEW OF CARE MANAGEMENT IN SCOTLAND

SCOTTISH EXECUTIVE
The views expressed in this report are those of the researchers and do not necessarily represent those of the Department or Scottish Ministers.
ACKNOWLEDGEMENTS

The authors would like to thank everyone who contributed to this study – the service managers and care managers who took part in telephone interviews and the staff and service users who arranged, or made us welcome during, the case study visits. We are particularly grateful to Charlotte MacDonald for her advice on questionnaire design and analysis and for her helpful comments on a first draft of the report. Sheena Conroy and Pam Lavery provided invaluable secretarial assistance. Thanks also to Mike Wilson for his help with data entry, Monica Barry for proof-reading and Gillian McColgan for her input.
## CONTENTS

### LIST OF TABLES

### GLOSSARY OF TERMS

### EXECUTIVE SUMMARY

<table>
<thead>
<tr>
<th>Chapter One: The Policy and Research Background</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>8</td>
</tr>
<tr>
<td>Policy and Research Background</td>
<td>8</td>
</tr>
<tr>
<td>Aims of Present Study</td>
<td>14</td>
</tr>
<tr>
<td>Methods</td>
<td>14</td>
</tr>
<tr>
<td>Summary</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Two: Overview of Structures and Activities</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>19</td>
</tr>
<tr>
<td>Objectives of Care Management</td>
<td>19</td>
</tr>
<tr>
<td>Role or Task?</td>
<td>21</td>
</tr>
<tr>
<td>Devolved Budgets</td>
<td>21</td>
</tr>
<tr>
<td>Profile of Care Managers Across Scotland</td>
<td>23</td>
</tr>
<tr>
<td>Joint Working</td>
<td>25</td>
</tr>
<tr>
<td>Profile of Care Managers in Study Sample</td>
<td>26</td>
</tr>
<tr>
<td>Caseloads</td>
<td>28</td>
</tr>
<tr>
<td>Numbers of Care Managed Cases Across Scotland</td>
<td>29</td>
</tr>
<tr>
<td>Estimated Proportion of Intensive Care Managed Cases</td>
<td>30</td>
</tr>
<tr>
<td>Summary</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Three: Screening and Assessment</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>34</td>
</tr>
<tr>
<td>Screening Referrals</td>
<td>34</td>
</tr>
<tr>
<td>Assessment</td>
<td>36</td>
</tr>
<tr>
<td>Summary</td>
<td>43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Four: Care Planning, Monitoring and Review</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>45</td>
</tr>
<tr>
<td>Care Planning</td>
<td>45</td>
</tr>
<tr>
<td>Monitoring</td>
<td>51</td>
</tr>
<tr>
<td>Review</td>
<td>54</td>
</tr>
<tr>
<td>Summary</td>
<td>59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Five: Training: Current Arrangements and Future Needs</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>60</td>
</tr>
<tr>
<td>Skills, Knowledge and Experience Needed by Care Managers</td>
<td>60</td>
</tr>
<tr>
<td>Professional Training</td>
<td>61</td>
</tr>
<tr>
<td>In-Service Training</td>
<td>62</td>
</tr>
<tr>
<td>Unmet Training Needs</td>
<td>64</td>
</tr>
<tr>
<td>Summary</td>
<td>66</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Six: Case Study Visits: Scottish Borders and Moray</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>68</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>68</td>
</tr>
<tr>
<td>Moray</td>
<td>75</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Devolved budgets</td>
<td>14</td>
</tr>
<tr>
<td>2.2</td>
<td>Employers of care managers</td>
<td>16</td>
</tr>
<tr>
<td>2.3</td>
<td>Location of care managers across Scotland</td>
<td>16</td>
</tr>
<tr>
<td>2.4</td>
<td>Care managers’ professional backgrounds</td>
<td>17</td>
</tr>
<tr>
<td>2.5</td>
<td>Professional background of care manager sample</td>
<td>18</td>
</tr>
<tr>
<td>2.6</td>
<td>Range of user groups the care managers worked with</td>
<td>19</td>
</tr>
<tr>
<td>2.7</td>
<td>Estimated number of care managed cases by user group</td>
<td>21</td>
</tr>
<tr>
<td>3.1</td>
<td>Aims of screening</td>
<td>25</td>
</tr>
<tr>
<td>4.1</td>
<td>Factors influencing service allocation (care managers)</td>
<td>37</td>
</tr>
<tr>
<td>4.2</td>
<td>Care managers’ reported knowledge of unit costs of in-house services</td>
<td>37</td>
</tr>
<tr>
<td>4.3</td>
<td>Care managers’ reported knowledge of unit costs of external services</td>
<td>38</td>
</tr>
<tr>
<td>4.4</td>
<td>Degree of choice available to users: care managers’ perceptions</td>
<td>38</td>
</tr>
<tr>
<td>4.5</td>
<td>Potential frequency of monitoring packages as reported by care managers</td>
<td>42</td>
</tr>
<tr>
<td>4.6</td>
<td>Type of monitoring contact reported by care managers</td>
<td>42</td>
</tr>
<tr>
<td>4.7</td>
<td>Responsibility for on-going monitoring: care managers’ and service managers’ perceptions</td>
<td>43</td>
</tr>
<tr>
<td>4.8</td>
<td>Forms of on-going monitoring reported by service managers</td>
<td>44</td>
</tr>
<tr>
<td>4.9</td>
<td>Aims of review (as reported by service managers)</td>
<td>45</td>
</tr>
<tr>
<td>4.10</td>
<td>Frequency of review for community-based packages</td>
<td>46</td>
</tr>
<tr>
<td>4.11</td>
<td>Circumstances prompting case closure</td>
<td>49</td>
</tr>
<tr>
<td>5.1</td>
<td>Skills, knowledge and experience needed by care managers: service managers’ perceptions</td>
<td>51</td>
</tr>
<tr>
<td>5.2</td>
<td>Care managers’ perceptions of how well their professional training had prepared them for care management</td>
<td>57</td>
</tr>
<tr>
<td>5.3</td>
<td>Perceived effectiveness of training</td>
<td>58</td>
</tr>
<tr>
<td>5.4</td>
<td>Reported unmet training needs of care managers</td>
<td>61</td>
</tr>
</tbody>
</table>

LIST OF FIGURES

| Figure 2.1 | Intensive Care Management | 22 |
GLOSSARY OF TERMS USED IN THE REPORT

**CCO:** Community care officer

**CMHT:** Community Mental Health Team

**CNO:** Chief Nursing Officer

**CPA:** Care Programme Approach

**CPN:** Community psychiatric nurse

**CarenapD:** Care needs assessment package for dementia: an assessment form/process for use with people with dementia

**CarenapE:** Care needs assessment package for the elderly: an assessment form/process for use with older people

**DN:** District nurse

**ILF:** Independent Living Fund

**LHCC:** Local Health Care Co-operative

**OT:** Occupational therapist

**RAT:** Rapid Assessment Team

**RRT:** Rapid Response Team

**SSI:** Social Services Inspectorate (for England and Wales)

**SWSI:** Social Work Services Inspectorate (for Scotland)
EXECUTIVE SUMMARY

THE POLICY AND RESEARCH BACKGROUND

1 Research across the UK during the 1990s found inconsistency and lack of clarity regarding the aims of care management and the roles and responsibilities of care managers. Studies found that care management is most effective when targeted at specific groups with high needs, within a multi-disciplinary context. Care management was characterised either as the role of a designated care manager (the ‘role’ model) or as one task amongst others (the ‘task’ model).

2 In 2001 the Scottish Executive accepted the recommendations of the Joint Future Group Report that care management be redefined as intensive care management, targeted at people with complex, or frequently or rapidly changing needs. However, the report did not define what it meant by that term.

3 This research aims to identify how local authorities in Scotland are currently using care management to support people at home. Telephone interviews were held with a service manager and care manager in every authority, making 64 in all. Case studies were conducted in five authorities, selected for contrasting approaches and according to certain ‘good practice’ criteria.

OVERVIEW OF STRUCTURE AND ACTIVITIES

4 There was great diversity of views among authorities regarding the objectives of care management. The most frequently identified objectives were to meet need and to support people in their own homes. Many objectives identified reflected wider aims of community care or aspects of the care management process, suggesting a blurring of focus in some authorities.

5 Only one authority was using the ‘role’ model of care management; in 22, it was a ‘task’, while ten authorities reported a mixture of ‘role’ and ‘task’.

6 Only one authority has devolved budgets to all care managers. In three authorities, the whole care budget was devolved to team managers, and in 21, part of it was. Seven authorities had no devolved budgets. Even where budgets were devolved to team level, care managers often had to seek approval from higher level before purchasing certain types of care.

7 Accurate figures about the number of care managers across Scotland were difficult to obtain. However the reported number of full-time equivalent (FTE) care management posts in 29 authorities was 1833. Of these, 147 staff were employed by agencies other than social work departments, including 115 employed by NHS trusts. While most posts were located within local authorities, 196 were in hospitals, 93 in
primary care settings and 64 in the independent sector. 309.5 care management posts were said to be located in multi-disciplinary teams. Joint working was seen as key to good practice and was often identified as an example of what was, and what was not, working well. The vast majority of care managers were social work trained but 164 had a background in occupational therapy, 151 in nursing and 89, in home care.

8 The profile of the 32 care managers who took part in the study was not greatly dissimilar, although there was a higher proportion of nurses among them.

9 These 32 care managers were carrying between 6 and 117 care managed cases each, the mean being 34. They estimated they had between 5 and 51 intensive care managed cases, with a mean of 23, representing about two thirds of all their care managed cases. High caseloads were repeatedly identified as a problem for care managers.

10 Many authorities had difficulty supplying information about the number of care managed cases in different user groups. The findings indicate great inconsistency in the way data are recorded across Scotland, with figures relating to care management being far from universally available or reliable. Some authorities did not know how many care managed cases they had.

11 It was estimated that in 26 authorities there was a total of 128,229 care managed cases. The largest group was older people, followed by those with physical impairment and dementia. (Six authorities did not supply any figures).

12 Sixteen service managers gave estimates for the total number of intensive care managed cases within their authorities: again, their responses showed significant diversity, with eight estimating that these cases accounted for less than 40 per cent of all care managed cases, and four estimating they accounted for over 80 per cent.

SCREENING AND ASSESSMENT

13 When screening referrals, authorities varied in the way they made decisions and the extent to which they differentiated between different types of decision. A few believed it would be premature to decide on the complexity of a case at the point of screening, while others were making some decisions about services.

14 Twenty one authorities reported that their screening procedures targeted people with complex needs for care management.

15 In five authorities, no-one was responsible for supervising screening. Ten of the 17 care managers involved in screening had not been trained how to do it.

16 In 24 authorities, there was some differentiation between staff carrying out different levels of assessment, with qualified staff taking on complex cases. Most also
had some degree of specialisation in terms of user group, particularly users of mental health services and people with learning disabilities.

17 The picture across Scotland is a long way from comprehensive use of single shared assessment tools for older people and those with dementia: the Joint Future Group proposed this should be implemented by October 2001. Only one authority had such a tool for all user groups which it had piloted and was about to implement across the authority. Fifteen authorities were piloting shared assessment tools or using them within specific teams or projects. Difficulties were sometimes experienced obtaining specialist assessments.

18 The involvement of housing colleagues was at a much lower level, with most only being consulted once a specific housing need had been identified. There were some examples of joint initiatives however.

19 Only one care manager reported difficulty co-ordinating different professionals’ contributions to assessment.

20 Although all but one authority had some form of independent advocacy, access was restricted in 18. Very little thought had been given to how best to involve people from ethnic minority communities in assessment. About half the authorities did not routinely offer carers an assessment of their own needs.

21 Eight authorities reported that assessment was fully separated from service delivery, eighteen, partially and six, not separated at all.

**CARE PLANNING, MONITORING AND REVIEW**

22 Nineteen care managers were aware of cost ceilings for individual care packages, eight reported that none existed, while five did not know if they did or not. Just under two thirds of care managers knew the unit costs of in-house and external services, while just under a third had some knowledge of both. Given the limited spending authority which most care managers enjoyed, however, these findings are less significant than they might appear.

23 About half the care managers did not think there was enough good quality provision locally to give users a choice of ways to meet need, and a higher number did not believe there was enough choice between types of service. Although older people were seen as having more choice than other groups, in reality this was usually a choice between various residential or nursing homes. The type of service seen as offering least choice was short term care, while domiciliary care options were also fairly restricted.

24 Twenty four care managers faced restrictions imposed by the authority which limited their access to a range of service providers. These included prescribed provider lists and having to use in-house services first.
Although there were some impressive exceptions, the extent to which round-the-clock cover could be provided to people in their own homes was generally very restricted. In some areas, a picture emerged of older people moving into residential or nursing homes if that was cheaper than supporting them at home. Authorities had more success in supporting disabled people, those with learning disabilities and users of mental health services, largely because other sources of funding were available, such as resource transfer, direct payments or Independent Living Fund (ILF) monies. Financial and resource constraints were the aspects of care management most often identified as problematic by both care managers and service managers.

Only 20 authorities reported that all cases were reviewed. Overall there was some lack of clarity about how and when monitoring and review should be carried out, with perhaps too much monitoring and too little reviewing taking place.

Some care managers reported that certain cases would never be closed: these were not all intensive cases.

Service managers had high expectations of care managers in terms of skills, knowledge and experience. Assessment and ‘people’ skills were seen as the most vital attributes, with knowledge of resources, finance and legislation also being important.

Just over half the care managers felt their professional training had been a useful preparation for care management, while a smaller number did not. This was not related to discipline.

Eight care managers reported they had received no training in care management. Just under half the care managers had been given some input on aspects of the care management process but this was often several years ago. Consequently, some said that lack of clarity surrounding the care management role was a problem. In 21 authorities, some joint training had taken place, usually with health colleagues.

Despite the fact that they were responsible for care management in their authorities, nine service managers had not had any training in it and, overall, they had received less training than care managers.

A long and diverse list of unmet training needs was identified among care managers. Most often mentioned were law, finance, specific user group issues and the role and tasks of care managers. This review indicates that training in screening and care planning would also be useful. Different levels of training are needed to suit differing levels of experience.
THE FIVE LOCAL AUTHORITY CASE STUDIES

33 Two of the case study authorities, Scottish Borders and Moray, offered care management to all community care clients, while the other three, Inverclyde, Clackmannan and Aberdeenshire, targeted only those with complex needs. Aberdeenshire has written criteria regarding eligibility for care management.

34 However, Borders and Moray also differentiated between clients with different levels of need. The intention was that this should be reflected in the nature and level of care management offered to different clients. It seemed this policy was not always systematically applied in Borders, with some workers carrying out full assessments of all clients, and difficulties being experienced carrying out reviews. Moray had a system of ‘pooling’ stable cases for review purposes. Care managers in both authorities tended to have high caseloads.

35 Borders and Moray differed in their use of unqualified staff. In Borders, the latter do not take on complex cases. If a case assigned to an unqualified worker turned out to be more complex, it was passed on to a qualified care manager. In Moray the policy was that unqualified staff can carry complex cases with support from qualified seniors. However, the latter reported that in practice this caused some difficulty.

36 It was striking that of the five authorities selected for case study visits, only one was (mainly) an urban locality. The rural authorities faced particular challenges in organising care management, including scarcity of resources, transport problems and potential isolation of users. However, these factors had encouraged authorities to be resourceful and creative, as reflected in a number of initiatives.

37 Aberdeenshire was unique in having delegated budgets to care manager level, thus giving individual staff a high level of autonomy in purchasing decisions. Having access to sound financial information and clear spending guidelines were key to good budget control by care managers.

38 Inverclyde and Clackmannan are two of the smallest authorities in Scotland. Decision making, although not in the hands of individual care managers, was seen to be quick, fair and could be easily influenced by the latter’s views. The size of these authorities made for close working relationships between practitioners and managers, and between local authority staff and those in other agencies.

39 A number of benefits were reported for Eligibility or Approval Panels. These were:

- ensuring equity across an authority
- better budget management
- care plans which adhere to eligibility criteria.

Reported drawbacks were:
• delays in decision-making and implementing care packages
• disempowering of care managers
• panel members not best placed to take decisions about individual clients whom they did not know.

40 Other approaches for allocating residential and nursing home places included care managers making decisions on the basis of dependency scores, and pooling their individual budgets.

41 Each of the authorities was undertaking some level of joint working. These included a partnership approach to care management (Borders), joint assessment tools in various stages of piloting (all), a range of multidisciplinary teams (all), including a housing professional within a Community Mental Health Team (Inverclyde), a Rapid Assessment Team (Inverclyde), community dementia teams (Aberdeenshire) and the alignment of home care and community nurses (Moray).

42 The Carefirst IT package was highly approved by those using it. Clackmannan, Moray and Aberdeenshire each had well advanced plans for sharing IT systems with health colleagues, albeit on specific projects.

43 Borders was one of the few authorities in Scotland to have organised joint training specific to care management, which had been independently evaluated. Staff reported that this had promoted a greater understanding of each others’ roles.

CONCLUSIONS AND IMPLICATIONS FOR POLICY AND PRACTICE

44 Authorities reported a very diverse range of policies surrounding ‘care management’. There were three reasons for this:

• inconsistent use of terminology between, and possibly within, authorities
• differences in policy and practice between authorities
• lack of clarity about certain aspects of care management.

45 These separate points also impact on each other. Terminology can mask differentiation in policy and practice, if the same words are used to denote different things. Conversely, policy and practice with much in common may be presented differently. This was most critical in relation to the term care management, with some authorities saying they only care manage people with complex needs and others offering care management to all their clients. There were also variations of practice within these two groups.

46 There is a need for a clearer differentiation between complex and more straightforward cases, matched by a clearly differentiated process for each, with different terminology used to describe these processes. These might be:
• information and advice-giving and the provision of very simple services, such as bus passes
• care co-ordination, aimed at people with relatively straightforward and/or stable needs, involving the provision of simple services
• care management (or ‘intensive care management’) offered only to people with complex or frequently or rapidly changing needs, requiring complex packages of care and active, on-going support.

The last of these would only be carried out by qualified care managers. Unqualified staff could be care co-ordinators. These arrangements are of course well established in some authorities.

47 It would be helpful to clarify what is meant by a single shared assessment tool. It will be necessary to reconsider the target dates set out in the Joint Future Group report for the implementation of such tools across Scotland.

48 The research also points to a need to reconsider the number of intensive care managed cases which care managers should be expected to carry. The findings suggest that 15 is about the right number, as opposed to 40 - 45, the figure proposed by the Joint Future Group report (unless 30 of these are open for review purposes only).

49 There is a need to develop closer joint working between care managers and housing professionals. Some examples of good practice are identified in this report.

50 There is a need to improve response times when health professionals are asked to provide specialist assessments.

51 Authorities would benefit from more encouragement and guidance in devolving budgets to care manager level. Overall, devolved budgets seemed a better way of making purchasing decisions than the use of panels.

52 The findings indicate an urgent need to consider allocating more resources to care management.

53 Care managers and service managers would benefit from training in a number of areas but particularly with regard to

• relevant legislation
• financial systems and budgetary skills
• the role and tasks of care managers
• screening referrals
• care planning.
CHAPTER ONE: THE POLICY AND RESEARCH BACKGROUND

INTRODUCTION

1.1 This report presents the findings of a study commissioned by The Scottish Executive Central Research Unit and carried out at the Social Work Research Centre at Stirling University between March and August 2001. The main aim of the study was to identify the ways in which local authorities in Scotland are currently using care management to support people at home. Telephone interviews were carried out with a care manager and a service manager in each of the 32 local authorities in Scotland and case study visits were made to five areas.

1.2 The first chapter of the report sets out the policy and research background to care management. The two are discussed in tandem because this is an area of social policy in which research has had a relatively significant impact. This chapter also identifies the aims of the present study and describes how it was carried out. Chapters 2 to 5 present the findings from the telephone interviews while the case studies are presented in Chapters 6 and 7. The final chapter draws out the conclusions of the study and the implications for policy and practice in the future.

POLICY AND RESEARCH BACKGROUND

Early care management

1.3 Care management was first developed in the United States during the 1970s and 80s as a way of tackling concerns about the growing costs of long-term residential care and increasing service fragmentation. The federal government commissioned a series of ‘channelling’ projects, charged with setting up new organisational structures and operating systems which would match services to needs in long term care (Davies and Challis, 1986a). Researchers at the Personal Social Services Research Unit at the University of Kent drew on these projects to develop their own approach to community care, and particularly care (originally called ‘case’) management. Key features included care managers with control of substantial resources being able to design and purchase intensive support packages for individual users. The UK pilot schemes also proved highly successful in supporting frail elderly people in their own homes (Challis and Davies, 1986b, Challis et al, 1997). The Government subsequently identified assessment and care management as ‘the cornerstone of high quality care’ (Secretaries of State, 1989, 1.11) in the White Paper which preceded the NHS and Community Care Act of 1990.

1.4 The new legislation was accompanied by detailed guidance for both managers and practitioners which set out the policy and practice of care management (SSI/SWSG 1991a, 1991b). It was described as a process consisting of seven different stages:
• publishing information
• determining the level of assessment (‘screening’)
• assessing need
• care planning
• implementing the care plan
• monitoring
• reviewing.

1.5 In identifying what was distinctive about care management, the guidance set out the following features:

• separation of assessment of need from consideration of how to meet need, and from service provision
• tailoring services to meet individual need
• delegation of budgets to care managers, enabling them to buy in services from a range of sectors
• active co-ordination of services by one individual
• one named individual nominated as a key reference point for service users
• the empowerment of users and carers, who should be closely involved in the whole process
• identification and recording of unmet need, to assist future planning.

1.6 However, some aspects of implementation were left to local discretion. For example, the guidance stated that authorities would probably want

“to give priority to users with complex needs or those requiring significant levels of resources…Those at risk of requiring substitute care, particularly on discharge from hospital, will be candidates for early consideration.” (SSI/SWSG 1991a, 3.8).

It would be for authorities to decide the pace at which care management was extended to other groups ‘with lesser needs’. However, the guidance also stated that the eventual goal was to enable all users and carers to benefit from some kind of care management arrangement (SSI/SWSG, 1991a, 71). It is worth bearing this in mind in the light of recent calls from the Scottish Executive concerning intensive care management (discussed below). The guidance also set out a range of different organisational models, and variations on models, for both assessment and care management. While the guidance might be commended for avoiding prescription, it might also be criticised for being open to different interpretations and potentially confusing.

1.7 As part of a major evaluation of the introduction of community care in Scotland, two models of care management were identified - the ‘role’, whereby staff were designated care managers and this was all they did, and the ‘task’, whereby social
workers carried out care management tasks alongside other duties, including service provision. The latter could be located within a social work department or shared between two agencies (Buglass, 1993). Considerable variation existed throughout Scotland in the type and level of assessment available, assessment was not always separated from service delivery and there were no devolved budgets (Stalker, 1994). Petch et al (1996) reported considerable confusion among social workers about what exactly care management was and who should receive it: staff and workers in other agencies were still on a ‘learning curve’ about needs led assessment.

1.8 Baldwin (1995), in a study of care management in two English local authorities, identified a tension between discretionary behaviour and prescriptive practice. He found that uncertainty about care management was leading to inconsistent practices and unclear roles. On the one hand, some workers were wedded to a professional agenda which was individual based and problem focussed, while others were adopting a more managerialist approach, emphasising procedures and paperwork. Targeting resources on the most needy was not necessarily seen as an effective policy, since early identification and provision of resources could prevent later breakdown. Baldwin found that review deadlines were often missed due to pressures of work, while other cases were receiving a social work service under the guise of monitoring. Baldwin concluded that assessment and care management are ‘concepts with contested meaning’, subject to differing interpretations depending on whether they were seen as part of a managerial, professional, service user or political agenda.

1.9 Lewis and Glennerster (1996) looked at the implementation of care management in five English authorities with contrasting political and demographic features. The authors suggest that lack of prescription within the guidance and its fragmented nature meant that a bottom-up approach to implementation was required. They found a very diverse set of responses to the reforms at local level, which, they argued, depended on “whether the authority was able and willing to interpret the changes in a manner that made sense to it” (p 199).

1.10 An inspection of arrangements in seven local authorities south of the border (SSI, 1998) found that objectives for care management “had shifted, were unclear and /or not explicit” (3.3). Links with commissioning were not equally developed across authorities, and scope existed for greater devolution of budget responsibilities. All the authorities were having some problems coping with reviews, especially where there was no differentiated approach tailored to user circumstances. Information systems and information flow were also problematic, for example, some authorities lacked data about unit costs, budget profiles and even accurate information about individual assessments. More positive findings were the benefits accruing from direct access by primary care staff to social care resources, which increased the user’s sense of a seamless service, the effective contribution which administrative staff could make throughout the system, so long as training and supervision were available, and some examples of good practice relating to the involvement of people from ethnic minority communities.
Recent developments

1.11 Challis et al (1997) drew a distinction between ‘generic’ and ‘intensive’ care management. The latter was marked by an ongoing involvement in cases by care managers, close working with health colleagues and service providers, and small caseloads. The process was helped where care managers in specialist teams had a key role in case finding and screening. Care managers having the resources to recruit or purchase external support (such as independent home care, to match individuals’ particular needs, rather than slotting them into a prescribed service), was another key factor in effectiveness. Challis et al emphasised the findings of other studies showing that the most effective care management interventions were targeted at a specific user group with high levels of need and specific problems. The authors speculated that, in order to provide a differentiated service targeted at those most in need, social care systems might have to develop a primary/secondary distinction similar to health care.

1.12 However, mixed accounts about the effectiveness of joint working continued to be reported. Lanshear et al (1999) found that the approach used in a pilot scheme in Devon, involving the placement of a care manager in a GP surgery, with extra hours allocated for supporting carers, compared favourably with more traditional methods of providing carer support. The professionals involved in this pilot reported that collaboration between social services and health colleagues had improved and that this in turn had enhanced the service they were able to provide. In contrast however, Lloyd (2000), examining the community care arrangements available to people with Parkinson’s Disease, identified a number of serious problems in the way needs were assessed and met, which she attributed to ‘weaknesses at the health and social care interface’. Very few people visiting their GP or a consultant neurologist were referred on for social care assessments and services. Traditionally, Lloyd argues, services to people with Parkinson’s and other chronic medical conditions, were made available from a specialist medical core: this no longer matches with social care delivery systems, but limited resources prohibit having a care manager attached to every specialist operational unit within the health service. Lloyd suggests that one way to create sustainable links between social services and specialist medical ones is to develop the role of the user as his or her own care manager, since they have the potential to contact and ‘go between’ different systems.

1.13 Ramcharan et al (1999) carried out surveys of care management in Wales in 1995 and 1997, by sending postal questionnaires to care managers. They found that assessments had become increasingly time consuming. As a result, by 1997, practitioner had spent less time with users on a one to one basis. There were no devolved budgets, although staff did work to an expenditure ceiling. The authors speculated that these factors were likely to limit creativity and imagination in designing care packages. Where a purchaser/provider split was in place in mental health and learning disability services, the loss of user contact contributed to care managers feeling ‘de-skilled’. Where there was no such division, care managers had more time for users and for ‘indirect’ work, leading the authors to question the appropriateness of implementing the purchaser/provider split across specialisms. Different models of care management, they suggest, may be effective with different groups.
1.14 Thistlewaite (1999) appears to suggest that certain tensions are inherent within care management and that, in the interests of cost control and volume management, a certain amount of pragmatic compromise of its underlying principles is unavoidable. He points to evidence from North America and Australasia which, he argues, indicates that similar issues have arisen there and have not been resolved. Manthorpe (1999) also comments on the ‘mercurial’ nature of quality in care management when considered within the international context.

1.15 The Action Plan, *Modernising Community Care*, (Scottish Office, 1998) introduced no changes in policy but called for more effective joint working, more flexible services and delegated budgets. This was followed in 2000 by the Report of the Joint Future Group, again set up to find ways to make existing policies work better. The report identified two main problems associated with assessment and care management – first, over-assessment and secondly, inconsistency and lack of clarity in the development and targeting of care management nationally. Accordingly, the report recommended that, by October 2001, agencies should develop single, shared assessment procedures for older people and those with dementia, and for other user groups six months later. Care management, it was proposed, should be redefined as ‘intensive care management’, and only those who have undertaken training in this should carry it out. The report falls short however of defining what it means by ‘intensive care management’, other than stating that it should be aimed at people with complex, or frequently or rapidly changing needs, and referring to the Kent pilot projects. Indeed, it is not clear on what evidence or activities the Joint Future Group’s recommendations are based. Nevertheless, the Scottish Executive (2001a) responded by accepting the proposals. In its response to the Health and Social Care Committee’s 16th report, into the delivery of community care in Scotland, the Scottish Executive stated that

> “a key step in developing (intensive care management) is devolving budgets and spending authority to front-line staff...the development of close working relationships between Local Health Care Co-operatives and social work departments will also be crucial to the successful development of local solutions to care management and deliver.”

*(Scottish Executive, 2001b, 23)*.

1.16 As part of the Scottish Executive’s response to the Royal Commission on Long Term Care, the Chief Nursing Officer (CNO) was asked to progress work on the provision of free nursing care for older people. The CNO set up a Stakeholders’ Group to consider assessment of need and financial frameworks. It endorsed the Joint Future Group’s recommendation regarding a single shared assessment of need, preferably using CarenapE or a locally developed tool which met the criteria laid down by an Assessment of Need sub group, (Scottish Executive, 2001c). To this end, the CNO has worked on a number of pilot shared assessment tools with local authorities. The group stressed the need for multi-disciplinary training in the single assessment process.
1.17 These developments should be seen in the context of several other far reaching changes which are currently taking place, or being actively considered, within community care, and indeed social work, in Scotland. These include the introduction of the Scottish Commission for the Regulation of Care, the Scottish Social Services Council, The Regulation of Care legislation and the joint funding of community care services. Other initiatives, such as the extension of direct payments and of carers’ rights, also have implications for the future direction of care management.

1.18 Returning briefly to 1996, in that year a paper was published by one of the inspectors involved in the care management work conducted by the Social Services Inspectorate (SSI). Edwards (1996) draws a very useful distinction between what she calls three types of “care management” – the administrative, the co-ordinating and the intensive. The first of these is confined to information and advice giving, provided by administrative or reception staff, and comprises only a small proportion of care management work. The largest proportion, and this is very often aimed at older people, is taken up by the co-ordinating type. This involves the provision of a single service or a number of relatively straightforward services, which must be properly planned and co-ordinated. It can be delivered by staff with a range of vocational and professional qualifications but does not involve the care manager providing ongoing support to user or carer. Intensive care management, required by a much smaller number of people, is practised by a designated care manager who plans and co-ordinates services and also has a continuing therapeutic and supportive role. Edwards sets out the following criteria for intensive care management:

“Where the needs and/or circumstances of the user are complex, high risk and/or volatile, or
Where the care plan
  a) is volatile, or
  b) requires high-status co-ordination
Where a transfer of responsibility would jeopardise the user’s acceptance of ongoing assistance or rehabilitation.” (Edwards, 1996, p123).

Edwards’ typology could be criticised for including administrative and co-ordinating approaches as types of care management. However, the distinction between the three approaches to helping people, and the features described for intensive care management, are clear and useful, and will be referred to at various points in this report.
AIMS OF THE PRESENT STUDY

Aims

1.19 It is within this policy and research context that the Scottish Executive commissioned the present review of care management in Scotland. The overall aim of the study, as mentioned above, is to identify the ways in which local authorities in Scotland are currently using care management to sustain people at home. More specific objectives are:

- to identify local authority social work departments’ policies on the use of care management
- to identify how care management operates in practice in each local authority;
- to describe the user groups receiving care management
- to explore the extent to which budgets and spending authority are devolved to care managers and the extent to which they are able to exercise budgetary control
- to identify examples of good practice, focusing in particular on areas where integrated approaches to assessment and service delivery, including health, housing and social work, are being developed;
- to assess the extent to which care managers are currently carrying out intensive care management;
- to explore current training arrangements and views on the training needs of care managers.

METHODS

Part 1: The telephone interviews

1.20 Because previous research (Petch et al, 1996) had shown that care management policy and practice could vary within, as well as between, authorities, it was considered important to interview service managers (or the nearest equivalent) in order to obtain an overview of arrangements for care management across each authority. Equally, because practice on the ground can deviate from stated policies, it was necessary to interview practitioners as well. It was also desirable to interview these two groups separately, in case practitioners were inhibited in their comments by the presence of a senior manager.

1.21 For a number of reasons, it was decided to use telephone interviews, rather than face to face discussion, to collect data. It was thought likely that the data would be relatively straightforward and that the schedules would be a manageable length for telephone interviews. This method also had the advantage of being more time efficient, since one interviewer could conduct up to three interviews a day, and was able to interview staff in three different authorities in one day. This gave greater flexibility in arranging interview times with busy professionals.
The Central Research Unit had already gained agreement from the Research Standing Committee of the Association of Directors of Social Work for the study to be carried out. A letter was therefore sent to the Directors or Heads of Social Work in all 32 local authorities inviting their department to participate. They were asked to nominate a service manager responsible for care management and a care manager as interviewees. Authorities were asked to nominate care managers from a range of professional backgrounds and, where possible, from multi-disciplinary teams.

**Design of data collection tools: interview schedules**

1.23 Semi-structured interview schedules were designed. Service managers were asked about:

- care management policies: whom it is targeted at, who receives it; arrangements for joint working; devolution of budgets/ spending authority
- model of care management employed: role/ task or other
- number and designation of care managers, their professional background and location
- operation of care management/ overview of the different stages of the process
- number of flexible and intensive care packages in place; perceived barriers to developing more
- training: current arrangements and unmet needs
- what is working well overall
- what is more problematic.

1.24 Care managers were asked about:

- screening procedures and prioritising need
- operation of care management: practice at different stages of the process
- decision making and devolved budgets
- availability of a range of service providers/ support options
- extent to which responses are tailored to individual need
- examples of intensive care packages in place
- workloads
- training: perceived usefulness and unmet needs
- what is working well overall; examples of good practice locally
- what is more problematic.

The interview schedules were piloted with one authority and some minor amendments made. They are reproduced in full in Annex 1 and 2.

1.25 The schedules were sent to the interviewees in advance so they could reflect on the questions. In a few cases quantitative data were required which involved some advance preparation. The interviews lasted between 45 minutes and an hour and a half, most taking about an hour. With respondents’ permission, they were tape-recorded.
Although the timetable was tight, 32 care managers and 32 service managers were interviewed between mid April and early June.

Examination of policy and practice documents

1.26 Agencies were asked to make available any local policy documents and practice guidance relating to care management, and their screening and assessment tools. Over half the authorities did so. Details can be found in Annex 3.

Part 2: Case studies

1.27 The second part of the study consisted of five case studies, involving a more detailed examination of authorities with contrasting approaches to care management, and all including some good practice features. These were identified by drawing on the interview data and discussion with the Social Work Services Inspectorate (SWSI). The original proposal had been to select areas where there was evidence of most or all of the following features being present:

- a multi-disciplinary team including health, housing and social work
- an effective screening procedure enabling care management to be targeted at people with complex or frequently changing needs
- a single shared assessment process using an effective assessment tool
- budgets devolved to care manager level
- high level of user involvement
- other innovative or successful features.

1.28 In the event, however, very few authorities were found to have all or even most of these features. However those visited all had some: the reasons for selecting specific authorities are detailed in chapters 6 and 7 of this report.

1.29 During our case study visits, meetings were held with service managers, seniors and care managers. In some cases, we also met with colleagues from health who were closely involved in the care management process. In all but one authority (where users had to withdraw at short notice), we also visited users and/or carers in their own homes. Again, further details are given in the relevant chapters. The case study meetings with professionals were tape-recorded and part transcribed: notes were made about our talks with service users as soon as possible after each visit.

Data analysis

1.30 Some of the information collected during the telephone interviews was fairly structured, including some quantitative data, while other data were given in response to more open-ended questions. SPSS/PC offers a useful means of describing and analysing
mixed data of this kind. Coding frames were developed after three or four schedules had been completed for each sample and the schedules were then coded according to the categories created. The data were entered into SPSS (a computer data analysis programme) and frequency distributions and some cross-tabulations produced. Statistical analysis was not appropriate to the nature of the data nor the aims of the research.

1.31 Verbatim responses which seem to highlight an important point, or neatly encapsulate a frequently expressed view, were also recorded. Text of up to 255 characters can be stored on SPSS: longer responses were noted separately.

1.32 The data collected during case study visits were analysed manually. After carefully reading through all the notes, emerging patterns were identified, common themes explored and any unusual findings noted. Draft reports of each visit were sent to each case study authority. This allowed for checking of factual accuracy while also giving staff a chance to respond to our interpretation of the findings. Most made relatively few comments and, for the most part, these were incorporated in the final versions. The results of the case study visits were brought together with the findings from the SPSS analysis to produce this report. The policy and practice documents have been drawn on as a source of supplementary data for explanatory or illustrative purposes, or to provide background information on specific aspects of policy and practice where appropriate.

Limitations of the research

1.33 As future chapters will discuss, the terminology surrounding care management is used in very different ways across authorities. There may also have been differences in interpretation between interviewees in the same area. Consequently, some of the data collected for the study do not lend themselves to straightforward classification. Nor has it been possible within the scope of this study, in which a large amount of data had to be collected and analysed in a short time, to check out every response where meaning was unclear – although some such checking has taken place. It was found, for example, that some respondents tended to contradict themselves. Thus it is not always possible to be clear cut when presenting the findings. It should also be noted that questions to respondents sought information about care management across the board, and sometimes arrangements differed between user group. Where this was the case, and interviewees only worked with, or carried responsibility for, particular user groups, they were not always able to fill in the wider picture. Two respondents explicitly stated they were responding to questions in relation to the groups they worked with, and that arrangements for them differed in some respects from those for other groups in the authority. Similarly, because the review was expected to cover every aspect of the care management process and some related activities beyond, it has not been feasible to carry out an in-depth examination.
SUMMARY

1.34 This chapter outlined the development of care management across the UK, in terms of policy and research. Guidance accompanying The NHS and Community Care Act 1989 identified seven different stages to the care management process and a range of models for delivering it. Research across the UK during the 1990s found inconsistency and lack of clarity regarding the aims of care management and the roles and responsibilities of care managers. However, it has also been found that care management is most effective when targeted at specific groups with high needs and within a multi-disciplinary context. Edwards (1996) distinguishes between what she calls administrative, co-ordinating and intensive “care management”. In 2001 the Scottish Executive accepted the recommendations of the Joint Future Group report that care management be ‘reframed’ as intensive care management, targeted at people with complex, or frequently or rapidly changing needs. The aim of the present research is to identify how local authorities in Scotland are using care management to support people at home. Telephone interviews were held with a service manager and care manager in each authority. Case studies were undertaken in five authorities.
CHAPTER TWO: OVERVIEW OF STRUCTURES AND ACTIVITIES

INTRODUCTION

2.1 Drawing on data collected during the first part of the study from service managers and care managers, this chapter examines key aspects of the structure for care management across Scotland. The number, locations and backgrounds of care managers in each authority are discussed and data are presented about the estimated numbers of people in different community care user groups who are receiving care management. Findings are reported about caseloads and the proportion of cases estimated to be ‘intensive’ care management. The chapter begins by considering the objectives of care management across Scotland.

2.2 Although not all staff acting as care managers were called that (ie: some had other job titles), for ease of reference they will all be referred to as ‘care managers’ in this report.

OBJECTIVES OF CARE MANAGEMENT

2.3 Service managers were asked to identify the objectives of care management in their authority. One was unable to do so and did not forward information later. Broadly speaking, the remaining 31 authorities identified 24 different objectives. While a few respondents identified only one or two, many identified three or four, while a couple of authorities identified more. Analysis of the data shows that while some of the aims identified clearly related to care management (and could be called ‘primary objectives’), arguably, others are not aims of care management at all but rather, wider objectives of community care to which care management may contribute. These could be called ‘secondary objectives’. Others, such as ‘to co-ordinate/monitor/review’, might better be described as parts of the care management process, rather than its objectives. The responses are presented in these three categories below: it should be remembered that service managers did not classify them in this way. It is acknowledged that a case could be made for classifying certain aims differently. For example, assessing need could be seen as descriptive of process but after careful consideration, it has been classed as a primary objective. Numbers in brackets indicate how many service managers gave each response.

Primary objectives

- to meet need (12)
- to enable people to stay in their own homes (11)
- to assess need (9)
- to target appropriately (5)
• to ensure an individual needs led response (5)
• to co-ordinate multidisciplinary working (1)

Secondary objectives

• to promote choice (4)
• to support independence/ offer minimum intervention (3)
• to support carers (2)
• to develop services to meet unmet needs (2)
• to ensure quality (2)
• to be cost effective (2)
• to be accountable/meet targets (1)
• to eliminate bureaucracy (1)
• to ensure an equitable service (1)
• to provide flexible services (1)
• to develop local services (1)
• to ensure consistency of practice (1)
• to develop a mixed economy (1)

Descriptive of process

• to co-ordinate, monitor and review (8)
• to involve people in the process (4)
• to assess and manage the user/carer relationship (1)
• to determine levels of response (1)
• to secure necessary financial resources (1)

2.4 Only four of the total 24 types of response were each given by eight or more authorities. The most commonly reported objective was identified by just over a third. These findings indicate wide variation in the perceived objectives of care management across Scotland and, indeed, limited agreement. Thirteen authorities identified only objectives which have been classified as primary. (None of these authorities mentioned all five objectives in this category). Two authorities mentioned only aims which were descriptive of the process while the remaining 16 identified a mixture. It would be wrong to draw conclusions from the responses to this one question, but the findings suggest there may be some blurring of focus in relation to care management objectives in about two thirds of authorities. However, the literature reviewed in the previous chapter pointed to a weakness within the policy and practice guidance – that it lacked clear definition. Indeed, it also offers a largely descriptive account of the process, the underlying principles and the claimed benefits.

2.5 Given the Joint Future Group’s recommendation that care management be targeted at people with complex or frequently or rapidly changing needs, it is worth
noting that only five authorities mentioned targeting as an objective of care management. Three of these believed it should be aimed at people with complex needs or frequently changing needs. One referred to the ‘right people’ but did not specify who these were, while another mentioned a ‘select group’. Given this phraseology, it is interesting that one authority, in contrast, specifically stated that targeting was not an objective because, in its experience, this could lead to an ‘élitist’ service: rather, it was aiming to offer care management to all clients and thus, it argued, to provide a more equitable service across the board. How far and in what ways to target care management will be an important theme throughout this report.

ROLE OR TASK?

2.6 As noted in Chapter 1, previous research in Scotland (Buglass, 1993, Petch et al 1996) found that most authorities were implementing care management as a task – that is, a function carried out by social workers or other professionals as part of a wider role. Thus, while offering care management to some users, they would be providing a more traditional social work, nursing, occupational therapy or similar service to other – and some of the same – users. In contrast, where it was a role, staff were designated care managers, usually having that as their job title, and did not provide any kind of service. The Joint Future Group implies (but does not state) that this is its preferred model, since it recommends that no-one should undertake intensive care management who has not been trained to do so, and that care managers should carry 40-45 cases.

2.7 The present study found that the task model remains prevalent in Scotland, with 21 authorities (66%) using this approach. In only one case was care management described as a role, while ten authorities reported a ‘mixture’. This term covered various different arrangements. In a few cases, care managers in specialist teams, usually for people with learning disabilities or users of mental health services, followed the role model, while the task model was used in ‘generic’ community care teams. One authority had the reverse arrangement, whereby care management for older and disabled people was a role, while in specialist teams it was a task. A couple of authorities were moving towards increasing specialisation: here, the ‘mixture’ reflected a transition period. One authority had one team in which care management was a role: this was a joint pilot project in a health setting. In another authority, care management was treated as a role in a city but a task in rural areas. Finally, one authority reported that there were “a couple (of workers) who are clearly care managers”, perhaps implying this was an evolving rather than formal arrangement.

DEVOLVED BUDGETS

2.8 As discussed in Chapter 1, devolving budgets down to care management level was seen as a vital component in the success of the early care management pilot projects. The delegation of purchasing powers was key to enabling care managers to design and implement creative and imaginative care packages, allowing for flexible, individualised
packages of support. However, although authorities may be willing to devolve budgets to care managers within the confined boundaries of a pilot project, they may be less keen to do so on an authority wide level. For devolved budgets to be meaningful, there also needs to be a wide range of resources and support options available. These points will be considered in the next chapter.

Table 2.1  Devolved budgets

<table>
<thead>
<tr>
<th>Budgetary arrangements</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole care budget devolved to care manager</td>
<td>1</td>
</tr>
<tr>
<td>Whole care budget devolved to seniors/team manager</td>
<td>3</td>
</tr>
<tr>
<td>Part care budget devolved to seniors/care manager</td>
<td>0</td>
</tr>
<tr>
<td>Part care budget devolved to team manager</td>
<td>21</td>
</tr>
<tr>
<td>Whole budget remains with service manager</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

2.9 As Table 2.1 illustrates, in only one Scottish authority are budgets currently devolved to all care managers. Here, although there are minor regional variations in the practical arrangements, care managers have authority to spend up to £150 per person per week to prevent a client moving into residential care, and up to £230 to prevent admission to a nursing home. Within those limits, they have complete freedom to design a package and purchase care. If a user requires a more expensive package, approval is sought from seniors. In another authority, budgets are held by team leaders but in practice, we were told, care managers can request whatever they consider necessary for an individual package. This is almost always approved by team leaders, sometimes after having sought further information. Requests for approval and responses are e-mailed between care manager and senior, and usually agreed within a day. Thus it was argued that while not holding their own budgets, care managers did have considerable decision making powers. A decision had been taken not to devolve actual budgets to individual care managers on the grounds that this would be difficult to administer. It would be hard to predict the needs encountered, and therefore the costs required, by individual staff in a given period. This could result in some care managers having overspent budgets, and others under spent. In both these authorities, the total care management budget was devolved. More details about each are given in Chapter 7.

2.10 It is interesting to note that in two authorities where budgets had previously been devolved, this arrangement had been reversed and the money was now held centrally. In both cases difficulties had arisen. One service manager reported that budgets had become ‘very over-extended’: care managers in this authority attributed the difficulty to a lack of clear procedures and organisational infrastructure.

2.11 As the table shows, in most cases budgets were devolved to seniors and/or, more usually team leaders. One authority added that a specialist dementia worker had her own budget, while in another, GP practice budgets could be accessed by anyone. However, even where budgets – or parts of them - were devolved to team level, members were sometimes still required to seek approval from a higher level before purchasing certain types or levels of care. In some cases, agreement was needed from a service or operations
manager, in some cases, from a panel. Thus, practitioners’ spending authority was more limited than the table might appear to suggest.

2.12 Ten authorities reported that the budget for nursing and residential homes was held centrally (although the total number may be higher), while in two authorities, teams were allocated a number of places within homes. Besides long-term care, the services which could be purchased at team level included short term care, home care, day care, meals on wheels and alarms. Several authorities had devolved flexibudgets, used to purchase ‘non-mainstream’ services, while a few had budgets allocated to service development, designed to fill identified gaps in provision.

2.13 Care managers were also asked if they had a devolved budget. Surprisingly, two care managers reported that they did. One of these was only working with people with learning disabilities: he reported that ‘money’ was allocated to each user and that he used this to purchase support in consultation with the individual. However on seeking further clarification from a senior manager, it emerged that this was resource transfer money available as part of a resettlement programme.

PROFILE OF CARE MANAGERS: THE PICTURE ACROSS SCOTLAND

Number of care managers

2.14 Service managers were asked how many full time equivalent (FTE) posts were held by care managers, or staff acting as care managers, in their authority. Three authorities were not able to supply these data at the time of interview and did not send on the information later. Therefore we have figures for 29 authorities. One of the missing authorities was a large city: had its figures been available, the total number would have increased significantly. The other two authorities had smaller populations. The combined populations of the three authorities is 709,104 (Community Care, 1996).

2.15 The smallest number of care managers, in one island authority, was eight; the largest, in a big city, was 327. When these data were collected (April – June 2001) the total number of FTE care management posts in 29 Scottish authorities was 1833.

Employers of care managers

2.16 Table 2.2 shows the number of care managers, or staff carrying out care management tasks, employed by agencies other than the local authority.
Table 2.2  Estimated number of care managers by employing agency (other than social work department)
29 authorities

<table>
<thead>
<tr>
<th>Employer</th>
<th>No of Care managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Trusts</td>
<td>115</td>
</tr>
<tr>
<td>Voluntary organisations</td>
<td>28</td>
</tr>
<tr>
<td>Local authority housing departments</td>
<td>3</td>
</tr>
<tr>
<td>Private agency</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
</tr>
</tbody>
</table>

2.17 Fourteen authorities reported having some care managers employed by NHS trusts, the actual numbers in each area varying between one and 33. In six authorities some care managers were employed by voluntary organisations, and in two, by the local authority housing department. A few authorities pointed out that social work and housing were combined in one department.

Location of care managers

2.18 Service managers were asked how many care managers were based in each of various settings. The data supplied here should be treated with caution, as a significant number of respondents were unable to supply accurate figures and tended to offer approximate numbers instead. In these cases, the approximate number has been included in the data.

Table 2.3  Location of care managers across Scotland
29 authorities

<table>
<thead>
<tr>
<th>Location</th>
<th>No of care managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work department</td>
<td>1370</td>
</tr>
<tr>
<td>Hospitals</td>
<td>196</td>
</tr>
<tr>
<td>Primary care settings</td>
<td>93</td>
</tr>
<tr>
<td>Private agency</td>
<td>34</td>
</tr>
<tr>
<td>Voluntary organisations</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>1723</td>
</tr>
</tbody>
</table>

2.19 It was also reported that 309.5 care management posts (16 per cent of the total) were located in multi-disciplinary teams. For the most part, these were not additional figures to those quoted above. However, one authority which had not supplied any other figures reported having three care managers in multi-disciplinary teams. Joint working is discussed in more detail in the following section.
Care managers’ professional backgrounds

2.20 Table 2.4 gives details of care managers’ professional backgrounds. In this case, four authorities were unable to provide data. Some service managers gave approximate figures for certain categories – “about ten” or “around 15”: in these cases, the approximate number quoted has been included in the data. In a few cases, service managers responded by saying “a few” or “some”. This was most common in relation to the ‘other’ category. These responses have been treated as missing data. Therefore these figures are estimates.

<table>
<thead>
<tr>
<th>Background</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>1268</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>164</td>
</tr>
<tr>
<td>Nursing</td>
<td>151</td>
</tr>
<tr>
<td>Home care</td>
<td>89</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1714</strong></td>
</tr>
</tbody>
</table>

2.21 Not surprisingly, the vast majority of care managers were social work trained. The numbers with OT and nursing backgrounds were similar, each representing approximately 9% of the total number quoted. About half that figure had a background in home care. The number from ‘other’ backgrounds may seem higher than expected, despite being under-reported. These were mainly people with a background in voluntary work.

2.22 The data reported above indicate a total number of 1833 care management posts, while data for location of posts is given in 1723 cases and for professional backgrounds in 1714 cases. The apparent discrepancies between these numbers can partly be accounted for by the fact that some inexact responses have been treated as missing. Nevertheless the figures given by some authorities lacked internal consistency: when asked to clarify their data, not all of them responded.

JOINT WORKING

2.23 As mentioned above, it was reported that 309.5 care manager posts were located in multi-disciplinary teams. These were mainly specialist learning disability or mental health teams, drug and alcohol teams, or sometimes old age psychiatry or dementia teams. However that figure is likely to be an underestimate, since many authorities had rapid response teams, joint discharge and other teams which, unfortunately, it seems they did not always include in this calculation. Five authorities had no care managers formally
linked to or located within multi-disciplinary teams. Two authorities did not answer this question.

2.24 When respondents were asked to identify problematic aspects of care management, joint working was identified as the second most difficult area (reported by 13 care managers and 9 service managers). In particular, assessment was said to present difficulties in terms of multi-disciplinary collaboration, some service managers complaining of duplication of assessments and the absence of shared assessment tools. In their view, users could end up being given different forms and /or levels of service provision, depending which professional discipline had carried out their assessment.

2.25 However, when care managers were asked what aspects of care management they thought were working well in their authority, almost without exception, they responded in terms of positive relationships between professionals, effective networking and good liaison resulting in a range of service and supports. Just as the absence of good joint working was identified as a major difficulty, when effective collaboration took place, this was identified as a plus. It was said to result in greater flexibility, faster response times, better support and “resource management”, allowing priorities for care management to be agreed.

2.26 Some care managers specifically identified links with general practitioners as working well. They also identified particular projects in their own authorities as examples of good practice, such as rapid response teams, joint home care and nursing night services, early supported discharge schemes, links with housing, joint OT stores, dementia projects and various initiatives to develop new housing with care. The implementation of these projects had called for joint working between social workers, occupational therapists and primary care teams, along with voluntary sector agencies and home carers. There was a strong sense of pride in the perceived success of these initiatives, for example, in one project, the “blurring of professional boundaries” to provide diverse care plans.

2.27 At the same time, some comments on joint working indicate a sense of it still being ‘early days’ for care management, with references to future planned developments, rather than current practice, given as examples of what was working well. It was said that an understanding of the care management role was starting to emerge, and that care management was becoming more acceptable to other professions. Despite the fact that it was introduced ten years ago, some respondents appeared to see care management in a transitional state, with the need to forge better joint working before it could be described as fully operational.

PROFILE OF CARE MANAGERS IN STUDY SAMPLE

2.28 Having looked at data about care managers across Scotland, the next section examines characteristics of those in the study sample.
Job titles

2.29 Data were collected about the designations, professional backgrounds, employers and office base of the 32 care managers interviewed for the study. Reflecting the diverse arrangements for care management across Scotland, these 32 workers had 14 different job titles between them. The most common was ‘social worker’: this accounts for 15; there were also two senior social workers. Ten respondents had ‘care manager’ in their job title. In four cases this was followed by the name of the user group with whom they worked (discussed below); other variations included ‘social care manager’, ‘assessment and care manager’ and ‘nurse care manager and assessor’. The job titles of three workers referred to community care in general rather than care management specifically: these were ‘community care worker’, ‘senior community care worker’ and ‘senior community care officer’. The remaining job titles were ‘community occupational therapist’, and ‘social work and housing officer’. The latter was in effect two part-time posts. As indicated above, the sample included three seniors: it also included three mental health officers.

Professional background

2.30 The next table outlines the professional background of the sample, showing that the majority were social work trained. One person whose job title was care manager (learning disability) had a long-standing background in voluntary work in that field. She had no social work qualification but had recently undertaken ‘professional development and management training.’ The latter had covered ‘planning, budgets and training’.

Table 2.5 Professional background of care manager sample

<table>
<thead>
<tr>
<th>Prof. Background</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>22</td>
<td>69</td>
</tr>
<tr>
<td>Nursing</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Voluntary work</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

Care managers’ employers

2.31 Most of these care managers (29) were employed by the local authority, two were employed by an NHS Trust and one by a voluntary organisation. This was the Shetland Welfare Trust, a charitable trust set up through oil revenues. However this arrangement was due to change, at which point the care manager would become an employee of the local authority social work department.
Location of care managers

2.32 Finally, in terms of office base, 24 care managers were located within a community care team, five within a local authority specialist team and one in a generic social work team – this was an island authority. Two care managers worked between two bases - both worked part-time within a community care team and part-time in a specialist multi disciplinary setting.

Degree of specialisation

2.33 Over half the care managers had some degree of specialisation within their job, although the extent of this varied considerably. As Table 2.6 shows, 10 worked with one client group only while nine worked with two or more, but not all, client groups in community care. Thirteen care managers worked with all community care groups.

Table 2.6 Range of user groups the care managers worked with

<table>
<thead>
<tr>
<th>User group</th>
<th>No of care managers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All community care groups</td>
<td>13</td>
<td>40.6</td>
</tr>
<tr>
<td>Some or mixture of community care groups</td>
<td>9</td>
<td>28.1</td>
</tr>
<tr>
<td>Older people</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>People with learning difficulties</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>People with mental health problems</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>People with dementia</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

2.34 Comparing the findings about care managers across Scotland with those in the study sample (although the latter numbers are small), there is a higher proportion of care managers with a nursing background in the sample. In other ways they do not seem greatly dissimilar but it should be borne in mind that care managers were nominated for the study by authorities: the sample is not expected to be representative of the wider population of care managers.

CASELOADS

2.35 Care managers were asked how many care managed cases they were currently holding. The answers ranged from, at the lowest, 6, to the highest, 117. Clearly differences would be expected for a number of reasons, including number of hours worked, local interpretations of care management and policies on case management (i.e.: what ‘counted’ as an open or active case). The care manager who held 117 cases, although normally a part-time worker, had been working full-time for a year due to staff shortages. Many of his cases were ‘review’ cases and 42 were said to be complex. The
total number of care managed cases held by the sample was 1058, the mean being 34. Fourteen care managers also held some ‘non care managed’ cases, while 18 did not.

2.36 There was widespread feeling that caseloads were too high. When asked to identify problematic aspects of care management, volume of work and time pressures was among the three issues most frequently identified by both service managers and care managers. One respondent pointed out that most referrals were marked ‘urgent’, making prioritisation difficult.

2.37 Care managers were asked how many of their cases could be described as ‘intensive’ care management, using the description from the Joint Future Group that this should be aimed at people with complex or rapidly or frequently changing needs. The lowest reported number was 5 and the largest, 51. The total number was 705, with a mean of 23. Comparing the total figures given for care managed cases in their workloads with those deemed to be ‘intensive’, the latter make up 67 percent of the sample’s care managed cases, a point we will return to.

NUMBERS OF CARE MANAGED CASES ACROSS SCOTLAND

2.38 Service managers were asked to supply figures regarding the numbers of clients in different community care groups in their authority. These data need to be treated with extreme caution for a number of reasons. First, six authorities did not supply figures: two reported that they did not collect such data while four did not pass it on. This did not include any cities, but one large rural area with a sizeable population did not supply data. The combined populations of these authorities was almost 700,000 (Community Care, 1996). Secondly, as many as 15 authorities – over half those responding – commented that their data were likely to be inaccurate. Sometimes they believed the figures were under-estimates, sometimes they could not separate out two user groups into the categories being requested (for example, people with dementia were sometimes included along with older people) while some authorities pointed out that the data related to total numbers in each user group, rather than only those people who were receiving care management. This would result in significant over-estimates. Perhaps the most useful findings to emerge from this question – although they are not new – are:

- the inconsistency with which data are recorded across Scotland
- figures relating to care management are far from uniformly available or reliable
- some authorities did not know how many people they were ‘care managing’.

The findings also illustrate the problem about inconsistent use of terminology.

2.39 In the table below, the ‘sum’ shows the total figure reported for the 26 authorities that responded. The table also shows, under ‘no. of authorities’, how many authorities supplied figures for each category.
Table 2.7 Estimated numbers of care managed cases by user group

<table>
<thead>
<tr>
<th>User group</th>
<th>Sum</th>
<th>No. of authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people</td>
<td>59602</td>
<td>25</td>
</tr>
<tr>
<td>Physical impairment</td>
<td>21556</td>
<td>25</td>
</tr>
<tr>
<td>People with dementia</td>
<td>15221</td>
<td>24</td>
</tr>
<tr>
<td>Learning disability</td>
<td>8852</td>
<td>26</td>
</tr>
<tr>
<td>Mental health</td>
<td>7578</td>
<td>26</td>
</tr>
<tr>
<td>Drug and alcohol</td>
<td>3707</td>
<td>25</td>
</tr>
<tr>
<td>Disabled children</td>
<td>501</td>
<td>5</td>
</tr>
<tr>
<td>Sensory loss</td>
<td>705</td>
<td>8</td>
</tr>
<tr>
<td>Illness, incl. Terminal</td>
<td>132</td>
<td>2</td>
</tr>
<tr>
<td>Other (vulnerable)</td>
<td>367</td>
<td>2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>234</td>
<td>10</td>
</tr>
<tr>
<td>Offenders</td>
<td>213</td>
<td>2</td>
</tr>
<tr>
<td>Brain injury</td>
<td>74</td>
<td>2</td>
</tr>
<tr>
<td>Carers</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Non community care</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Homeless people</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (unknown)</td>
<td>9473</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>128,229</strong></td>
<td><strong>26</strong></td>
</tr>
</tbody>
</table>

2.40 Although the figures are no more than estimates, they do give a broad picture of the distribution of care management effort across user groups. Not surprisingly, older people are by far the most represented group, accounting for almost half (46%) of the total numbers reported. People with physical impairment are the second largest group, accounting for 17 percent of the whole. This number would increase if those with brain injury and sensory loss were added. People with dementia appear as the third largest group, at 12 percent. However, as noted above, some authorities included people with dementia within the category of older people. The table also indicates that, relatively speaking, people with learning difficulties and users of mental health services do not figure largely in the care management process, representing about 7 percent and 6 percent respectively. There are a number of categories with very small numbers: these are reproduced as reported since this reflects the range of recording methods within authorities, as well as the specific groups considered appropriate for care management. Only two authorities reported a figure for offenders: these individuals presumably had community care needs as well, one respondent describing them as having ‘mental disorders’. Only one homeless person was identified across authorities, also described as having ‘social work needs’. It is not known who fell into the ‘non community care’ category. One authority included a figure of 328 cases which were currently being assessed. These have not been included in the table.

**ESTIMATED PROPORTION OF INTENSIVE CARE MANAGED CASES**

2.41 Service managers were asked how many people were receiving intensive care management, in the sense used by the Joint Future Group report. Sixteen were unable to answer, some because their systems did not record cases in this way, others because they
considered the definition presently available to be insufficient. One respondent commented that he was not prepared to ‘second guess’ the Scottish Executive while others reported that they were awaiting further clarification. Generally there was a feeling that more central advice is needed. However, 14 authorities did offer a figure, although most emphasised that this was very much an estimate. The smallest number quoted was 48 and the largest, 3182. The total was 14,305 and the average across these authorities, 1022. Looking at these figures compared with the total number of care managed cases reported by these authorities, Figure 2.1 shows the respective proportion of care managed cases judged to be ‘intensive’. The figure includes two further authorities which could not supply an exact number of intensive care managed cases but nevertheless asserted that, in one case, “about 85 percent” of their work fell into this category and, in the other, that “all our care management cases, or almost all” coincided with the definition in the Joint Future Report. Both have been included in the 81–99 percent band.

2.42 These figures indicate significant diversity in the distribution of intensive care management cases across the 16 authorities. At the same time, eight responding to this question estimated that these cases took up less than 40 percent of the whole, while only four estimated they took up more than 80 percent. The two authorities which reported that all their care managed cases were of the intensive variety are discussed in more detail in Chapter 7. The third authority which appears as a case study in that chapter was unable to supply any figures for care managed cases and thus did not offer an estimate of the number of intensive cases. Evidence collected during the case study visit however strongly indicated that all their care managed cases would fall into this category. These
findings can be compared with the earlier finding that about two-thirds (67%) of the care managers’ workloads was estimated to comprise intensive cases. The higher proportion may be accounted for by the relatively high number of specialist workers within the sample.

2.43 Some more general points should be made here. As already mentioned, the guidance accompanying the introduction of assessment and care management stated that, in time, it was expected that all community care clients should receive some form of care management. According to Edwards’ (1996) typology of administrative, co-ordinating and intensive care management, the latter would be expected to account for only a small proportion of all care-managed cases. Thus it should not be surprising, and is not undesirable, that in a quarter of reported cases, intensive care management formed less than 40% of all care managed cases.

2.44 Some of the huge variation in reported distribution of activity, shown in Figure 2.1, can be accounted for by differences in terminology, and some by differences in policy and practice: it is important to distinguish between these. First, as we shall discuss in more detail in later chapters, a few authorities only care manage intensive cases, differentiating between levels of complexity to the extent that care management was not considered appropriate, nor was it offered to, those with lesser or more straightforward needs. Other authorities also care manage simpler cases, sometimes including those where services are in place and contact has been reduced to an annual review. However, there can also be significant differences between those that use the term ‘care management’ more widely. Thus for example, in one case study authority where all community care cases were care managed, there was still a differentiation between levels of care management and this was reflected at different stages of the process, for example, in less frequent reviews for simpler cases. In other cases however it seemed that the process was less adaptable to different levels of complexity or volatility within individual circumstances. This theme will be picked up later in the report.

SUMMARY

2.45 There was great diversity and little agreement between authorities regarding the objectives of care management, with many service managers identifying wider aims of community care, or parts of the care management process itself, as objectives. The findings indicate there may be some blurring of focus in about two thirds of authorities. The most frequently identified objectives were to meet need and to support people in their own homes. Few service managers identified targeting as an aim of care management, with one authority specifically arguing against care management becoming an ‘elitist’ service.

2.46 Only one authority is using the ‘role’ model of care management; in 21, it is a task, while ten authorities reported a mixture of ‘role’ and ‘task’. Only one authority has devolved budgets down to care manager level. In 21 authorities, part of the care budget was devolved to team managers, and in three, all of it was. There were no devolved
budgets in seven authorities. Even where budgets were devolved to team level, however, care managers often had to seek approval from higher level before purchasing certain types of care.

2.47 Reported figures about the numbers of care managers across Scotland were sometimes difficult to obtain and not always accurate. However the reported number of FTE care management posts in 29 authorities was 1833. Of these, 147 staff were employed by agencies other than social work departments, including 115 employed by NHS trusts. While most posts were located within local authorities, 196 were in hospitals, 93 in primary care settings and 64 in the independent sector. It was reported that 309.5 care management posts were based in multi-disciplinary teams. Joint working was seen as key to good practice: thus respondents often identified it as an example of what was, and what was not, working well.

2.48 The vast majority of care managers were social work trained but 164 had a background in occupational therapy, 151 in nursing and 89, in home care. The profile of the 32 care managers who took part in the study was not greatly dissimilar, although there was a higher proportion of nurses among them: however they were not intended to be representative.

2.49 These 32 care managers were carrying between 6 and 117 care managed cases each, the mean being 34. They estimated they were carrying between 5 and 51 intensive care managed cases, with a mean of 23, representing about two thirds of all their care managed cases.

2.50 Many authorities struggled to supply data regarding total numbers of care managed cases in different user groups. The findings indicate great inconsistency in the way data are recorded across Scotland, with figures relating to care management being far from universally available or reliable. Some authorities did not know how many care managed cases they had. However, it was estimated that in 26 authorities there was a total of 128,229 cases. Older people were by far the most represented group, followed by those with physical impairment and dementia. Sixteen service managers gave estimates for the total number of intensive cases within their authorities: again, their responses showed significant diversity across the country, with eight estimating that these cases accounted for less than 40 percent of all care managed cases, and four estimating they accounted for over 80 percent. This variation can be partly accounted for by differences in policy and practice, and partly by some misleading differences in the use of terminology.
CHAPTER THREE: SCREENING AND ASSESSMENT

INTRODUCTION

3.1 This chapter examines the initial stages of the care management process in more detail, looking at screening and assessment procedures. The data are drawn from the interviews held in Part 1 of the study with 32 care managers and 32 service managers.

SCREENING REFERRALS

3.2 In relation to screening referrals, the guidance on assessment and care management states that, when an ‘enquirer’ asks for more than information and/or advice, then enough basic information should be taken about needs to determine the appropriate level of assessment. The aim is “to establish as quickly and sensitively as possible, the urgency, level and complexity of needs” (SSI, SWSI, 1991, 2.10) so that each case can be allocated appropriately.

3.3 Seventeen of the care managers interviewed were involved in screening. Three others were not formally involved, but were consulted about specific referrals from time to time. The remaining 12 care managers did not screen referrals and so were not asked further questions about it.

3.4 Care managers were asked to describe the aims of screening. Their responses are contained in Table 3.1 and do not contain many surprises. While it might be considered that deciding on level of service (as reported by two respondents) is not an appropriate part of screening, many authorities, having decided whether a referral was a simple or complex case, referred on to home care, meals on wheels and so on.

Table 3.1 Aims of screening 17 care managers

<table>
<thead>
<tr>
<th>Aim</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine appropriateness of referral to department</td>
<td>8</td>
</tr>
<tr>
<td>Prioritise responses</td>
<td>7</td>
</tr>
<tr>
<td>Decide appropriate level of assessment</td>
<td>7</td>
</tr>
<tr>
<td>Decide appropriate professional to assess</td>
<td>6</td>
</tr>
<tr>
<td>Ensure good quality information</td>
<td>3</td>
</tr>
<tr>
<td>Decide appropriate service</td>
<td>2</td>
</tr>
<tr>
<td>Ensure a speedy response to minimise risk</td>
<td>1</td>
</tr>
</tbody>
</table>

3.5 According to service managers, the following staff were involved in screening referrals:
• social workers (in 24 authorities)
• seniors (18)
• team leaders (10)
• health staff (7)
• occupational therapy (OT) staff (6)
• admin. staff (5)

3.6 There were five authorities in which screening was only carried out by seniors (i.e., other professional staff were not involved) while in a further two authorities, screening was done by team leaders only. This finding begs the question of whether this is both a good use of team leaders’ time and an efficient way to process referrals, since team leaders are clearly busy with other tasks as well. Where administrative staff were involved, other professional staff also played a part.

3.7 Referrals came to departments in various forms. They were often taken by a duty team although there were variations. For example, one authority had a dedicated screening team called the Advice and Response Service. Here staff were able to respond to some queries by offering simple advice or information, dealt with simple cases which could last up to six or eight weeks, and passed on more complex ones to a longer-term team. This model corresponds to the administrative type of care management identified by Edwards (1996), although it might be argued that this is not care management at all. In some authorities, care managers linked to, or based in, GP practices received referrals direct from the GP. One authority had an open referral system in which all referrals were made direct to individual care managers linked to GP practices. The care manager screened these referrals, deciding which was an appropriate case to take up, and which to refer on to home care or elsewhere. This reduced the number of referrals being made to the social work department itself, and also ensured a more rapid response for the user. Most authorities had a recording form for referrals or used the OLM Carefirst system. Nine did not use any screening tool, while two identified specific screening tools such as the Barbour At Risk Register.

3.8 Screening itself consists of a series of decisions – whether or not the case is an appropriate one for the department, whether it is likely to be a simple or more complex one, and therefore what level of assessment is required, what the appropriate response time should be, and who should pursue it. The basis on which these various decisions were made, and the extent to which they were differentiated, appeared to vary considerably. Most care managers reported making decisions on the basis of referral information. Many would seek further information, usually by phoning the referrer, the user or the carer; however, a few would visit the client at this stage. Some care managers used set criteria, taking into account factors such as risk, the availability of informal support and the person’s physical and mental condition. Imminent hospital discharge created urgency, as did risk of admission. A few relied more on professional judgement, skills and experience.
3.9 Twenty-two service managers reported that their screening process targeted people with complex or rapidly changing needs for care management, in a further six cases, it partially did so while the remaining four did not target. However, only one authority reported having written criteria outlining eligibility for care management. Among the local authorities which estimated what proportion of their care managed cases were intensive, (see figure 2.1) on average, those which screened for intensive cases had a higher percentage of intensive cases than those which did not. In three of the four authorities which did not target, it was argued that ‘no assumptions’ should be made at the screening stage or that, while some referrals might receive a higher priority for assessment, the screening process did not target them as such. Similar comments were made by some authorities which ‘partially’ targeted people. Sometimes insufficient information was available at the screening stage to enable effective targeting to take place, even where this was the intention.

3.10 Various outcomes were identified for the screening process. Broadly, these were, or were to do with:

- offering advice, information or a simple service
- the appropriate level of assessment
- the urgency with which a client should be seen
- referring elsewhere
- taking no further action.

These outcomes appear to match the aims of screening identified earlier.

3.11 In 26 authorities, responsibility for supervising the screening process fell mainly to seniors and team leaders. In four cases, it was reported that service, area or operations managers also played some role in monitoring the process. Four authorities reported only that senior management was responsible. In five cases, nobody supervised screening, a finding which may cause some concern. However in all these authorities, seniors or team leaders were actively involved in the screening process.

3.12 Among the 17 care managers who were formally involved in screening, ten had received no training in how to do it. Three had been given a ‘one-off’ training session in-house, three received in-house training on a regular basis while one had been trained in screening while working elsewhere. However it is worth noting that, when asked about unmet training needs, no care managers nor service managers identified screening.

ASSESSMENT

Differentiation among assessors

3.13 In 24 authorities, there was some differentiation between staff carrying out different levels of assessment. Generally, complex cases were assessed by professionally
qualified staff, and more simple ones by those without professional qualifications, such as social work assistants or community care assistants. Simple assessments could also be carried out by occupational therapists (those not acting as care managers) or home care supervisors, where users appeared to have relatively straightforward needs in those areas. In three cases service providers, such as home link or day care, also carried out simple assessments. This is of course contrary to official guidance which argues for the separation of assessment from service provision (as discussed shortly).

3.14 In some authorities, this kind of differentiation was a hard and fast rule, in others, there was some flexibility due to pressure of work or availability of staff. Sometimes a case which initially appeared to be simple later turned out to be, or became, more complex. In these circumstances, in some authorities the case would be transferred to a more experienced worker, whereas in others, the unqualified worker would hold on to it, although perhaps with additional support or supervision. These authorities thought that, where a relationship was already established between worker and client, this should not be disrupted. In addition, there was variation within some authorities. Thus, in one authority home care staff within a disability team carried out assessments, but home care staff located elsewhere did not. In the remaining eight authorities, as a general rule, simple and complex cases were not routed to staff with different backgrounds or qualifications. One service manager told us that “a mix of cases for staff mean they all gain experience”.

3.15 In only six cases did the same staff assess different user groups. In most authorities, some degree of specialisation occurred, either at team level or, less formally perhaps, among individual workers. Usually, the specialist teams related to specific user groups, although a reception team could carry out simple assessments which were not routed to particular staff members. Users of mental health services were most likely to have specialist assessors (reported by 13 authorities), followed by people with learning disabilities (nine authorities), older people and those with dementia (each at six), disabled people (three) and finally those served by drug and alcohol or HIV teams (two).

**Single shared assessment tool**

3.16 There seemed to be some confusion among, or at least a number of interpretations by, service managers about the meaning of the term “single shared assessment tool”. Service managers were asked if there was a single tool, for use by different disciplines, within their authorities and many replied that there was. Closer examination of the data, however, reveals that not all respondents were referring to a single tool that could be completed by staff from different agencies, for example by either local authority or health, and accepted by other agencies. Some were referring to the fact that the same form was used by different disciplines within the local authority, or that health staff made some contribution to what was essentially a local authority assessment, or that the results of the assessment was shared with other colleagues.
3.17 At the time of writing:

- no authority was using a single shared tool for older people on an authority wide basis
- one has completed two pilots of a single shared tool for all user groups and is about to roll them out across the authority (see chapter 6)
- 15 were piloting single shared assessment tools
- 9 authorities were piloting or making some use of CarenapE
- 7 were piloting or making some use of CarenapD
- 3 were using single shared tools within Community Mental Health Teams (CMHTs).
- 11 authorities had not yet reached the stage of piloting a single tool, although several were ‘working on it’.

3.18 Where CarenapD and CarenapE were being ‘used’ as opposed to piloted, this was often confined to one team or project and did not always appear to be on a joint basis. Many authorities were still using the CCI, CC2 and CC3 assessment forms originating from Strathclyde Region in 1991 and/or other documentation produced in-house. Sometimes certain sections had their own assessment tools, for example, home care and augmented support teams.

The role of health colleagues

3.19 Only one service manager described local NHS colleagues as ‘not much involved’ in the assessment process, although he went on to say that district nurses were carrying out assessments as part of a pilot project. Most respondents were keen to stress their close working relationships with health. Three pointed out (although others could have done so) that nursing staff employed by the NHS could play a full care management role and thus be responsible for leading assessments. An important finding was that twelve authorities reported they accepted assessments carried out by NHS staff, although in most cases this was confined to specialist teams or hospital settings, or to simple assessments such as for occupational therapy equipment. Fourteen authorities talked mainly in terms of active contribution by NHS staff to local authority-led assessments, ranging from the provision of specialist assessments to completing a medical section on the assessment form. Eight framed NHS involvement in terms of consultation, where views were sought formally, by letter or case conferences or informally, by word of mouth, often for speed. Close working relationships on the ground were stressed, often between social work staff and community psychiatric nurses (CPNs), occupational therapists (OTs), district nurses (DNs) and, in one case, health visitors as well.

3.20 Half the authorities found it ‘very’ or ‘quite’ easy to secure specialist assessments, while half had more mixed experiences. The main difficulty was the length of time it took for completed assessments to be returned, described in one case as “weeks, even months”. The following problems were reported:
• GPs’ busy workloads
• GPs’ lack of understanding of care managers’ role
• disagreement about the appropriateness of a particular referral
• local authority had no budget to pay the GPs’ fee
• shortage of psycho-geriatricians
• difficulty accessing psychological assessments.

3.21 Overall, however, the problems should be seen in the context that all these authorities reported a mixed picture rather than a uniformly negative one; most also had something positive to say about effective results when requesting specialist assessments.

The role of housing colleagues

3.22 In contrast to the close involvement of health colleagues in assessment in many authorities, staff from local authority housing departments or housing associations were generally little involved in the assessment process. In five authorities they were described as having virtually no role to play: rather, they were seen as providers, a source of referrals or else the links were “issue-based”. In twenty authorities housing colleagues were consulted only where a specific housing issue or need arose during the assessment process. However the implication seemed to be that this was often on an informal basis, with only three service managers adding that a specialist assessment would be requested where appropriate, or in one case that a housing officer might be invited to attend a multi-disciplinary meeting where relevant. Some authorities pointed out that housing colleagues were more likely to be involved with certain user groups than with others, usually people with learning disabilities or users of mental health services. There was close joint working on a number of resettlement programmes. One authority implied (although did not specifically state) that housing colleagues were involved more routinely in assessment, being asked to complete a section about accommodation needs within the assessment form. Allocations panels or procedures existed in some areas for people with community care and housing needs.

3.23 Only four authorities reported examples of joint working which indicated that housing was more closely involved in the assessment process. One example is described in a case study in Chapter 7. The others were:

• a jointly funded and staffed housing and support team for 16-21 year olds which acted as the assessment and delivery team for that age group
• in one island authority, a social worker employed as an accommodation officer was able to conduct assessments in order to access single services
• one large rural authority had a post jointly funded by social work, housing and health to help develop “housing based solutions to community care needs”.

3.24 It was reported earlier that one authority had an OT care manager located in the housing section of a joint department while, in another authority, two OT care manager
posts were funded by housing. However no reference was made to these posts at this point.

3.25 Although a number of authorities combined social work and housing within the same department, there was little evidence that this necessarily resulted in closer links. One or two respondents did comment on the fact that they had a joint department and that positive links existed. Two respondents (not in joint departments) commented that links should be closer or that some thought was being given to involving housing colleagues at an earlier stage within the assessment process. What was perhaps more noticeable was the number of authorities reporting, without comment, on housing’s low level involvement. Nor were any specific barriers to joint working identified, as in some cases they were in relation to health. It is not known whether this is because for the most part such difficulties do not exist or whether, perhaps, joint working with housing in assessment is at such an early stage that any such barriers have not yet emerged.

Co-ordinating different contributions to the assessment

3.26 The majority of care managers explicitly stated, or strongly implied, that it was their responsibility to co-ordinate different professionals’ contributions to assessment. Several described the process of co-ordinating assessments much more as a joint activity, often carried out at multi disciplinary meetings. Most of these were based full or part time in multi-disciplinary teams and one was a nurse seconded to the local authority. Only one care manager based full time in a community care team talked about co-ordinating assessment as a joint activity carried out with a multi disciplinary team (in this case, a CMHT for older people).

3.27 Only one care manager reported difficulty in co-ordinating assessment, describing this as “still being developed”. Another reported that “social work has recently started co-ordinating this”, the implication apparently being that no-one had previously done so.

3.28 Completed assessments were shared with other professional colleagues in every authority: many respondents added that this was done with the user’s permission. How often users withheld permission, or what happened if they did, was not reported. One care manager reported that where an individual could not give informed consent, and there was no carer or advocate to do so on his behalf, she would note that fact on the form before circulating it. Six authorities qualified their comments by adding that information would only be shared on a need-to-know basis, two identifying a specific professional group to whom they would not circulate information.

Users’ and carers’ involvement in assessment

3.29 Users’ role in assessment was variously described as “prominent”, “vital”, “central”, “important”, “major”, “fundamental”, “fairly high”, “pretty essential”, “active” and “as full as possible”. Not much detail was given on how this prominent role was
played out in practice although many care managers asserted that users were involved at all stages in the process, were present at all meetings and discussions and had a say in all decisions. A few described their authority as very client centred, or having an open access policy. However, only one care manager referred to building up a relationship with users by getting to know them in order “to discern what they want”, while another tried to look at the individual’s needs from the latter’s point of view. One care manager reported that users must agree to be referred and want to be involved. Only a few gave a more muted account, describing users as being invited to give their views, or involved “depending on ability”.

3.30 However several care managers did identify difficulties communicating with people with dementia and, in one case, people who had experienced a stroke. Here care managers were guided more by the person’s behaviour and non-verbal communication, or relied on an advocate or person well known to the individual to facilitate communication. In all but one authority, there was some access to independent advocacy. However in 18 of them, this was restricted in some way. In some, it was available for certain user groups only, in others there was a long waiting list, while others had to arrange advocacy through another authority. The authority where advocacy was not currently on offer had plans and funding to start a scheme.

3.31 The extent to which measures were being taken to help people from ethnic minority backgrounds become fully involved in assessment was also explored. Five service managers reported that there were no formal arrangements of this kind. Only nine authorities reported that relevant information was routinely translated into community languages. It is possible that this is an underestimate since some may have omitted to mention it; however one or two specifically said that information was not translated. Two others reported having material translated when required. Twenty-three reported that interpreters were available, although sometimes these had to be called in from another authority. Similarly, seven authorities bought in the services of a voluntary organisation working with minority communities when appropriate. Other initiatives were:

- ethnic minority officer within social work department to work with clients as appropriate
- involvement of a voluntary organisation in a formal review of care management

3.32 Other developments mentioned related to service provision rather than assessment. Thirteen service managers commented on the low numbers of people from ethnic minority communities in their authority, one quoting a figure of less than 1 percent. While it is doubtless true that in some parts of Scotland, numbers are relatively low, there is a danger that this can lead to the needs of a few being overlooked. Although there is no evidence here to suggest it, there can also be a risk of perceived low level of need being used as an excuse to do little. Only four service managers commented that involving people from minority backgrounds was not well developed locally, or that more could be done.
3.33 Moving on to carers, again most care managers described them as having an important part to play in the assessment process. Their role was “active”, “major”, “quite prominent”, “very large”, “vital”, “integral”, or “very important”, and they were involved “fully” or “as much as possible”. While some care managers appeared to see the carer as a resource available to help support the user, others perceived the carer as a potential client in her own right. Some care managers referred - albeit implicitly - to both roles. Seven pointed out that there was a section in the user’s assessment form to record the carer’s views. Carers were seen as a valuable source of information, having better knowledge of and insight into their relative’s situation than care managers: they could also be “better historians than clients”. Where a user had dementia, care managers relied a great deal on carers to supply information. One care manager saw her role as “to support the carer to support the client” while another saw the carers as able to “provide input to support service provision”.

3.34 Ten care managers reported that they would offer carers a separate assessment of their own needs, although in some cases this was “always” done and in others “when required”. Looking briefly here at data collected from service managers, who were asked if carers were ‘routinely’ offered an assessment of their own needs, 17 replied that they were, eight said they did not know or could not be confident that this was so, while seven said this did not happen. Their responses indicated that this was an area which had not received a great deal of attention, with some authorities feeling they should be more proactive. Forthcoming legislation will require them to be so. One authority routinely offered a carers’ information pack.

3.35 However other respondents acknowledged that much depends on the relationship between user and carer. Seven commented that carers would only be involved in assessment if they wanted to be. A few felt it was important to talk to the user and carer separately, either routinely or as circumstances dictated. Five care managers would only involve the carer if the user was agreeable, while two were more wary of carers’ contributions. In their experience, carers’ views were often ‘in direct opposition’ to those of users, or carers could have “ulterior motives”. The view was expressed that the care manager was there to help the client first and foremost, and that the carer’s role was “less central”. On the other hand, another warned that “you exclude carers at your peril”. Some of the difference in care managers’ approaches to working with carers can be explained by the fact that they were working with different client groups. Those whose clients had dementia generally relied heavily on relatives for information; a care manager working on a resettlement programme supporting adults with learning disabilities to leave a long stay hospital commented that very few of her clients had any contact with relatives. The respondent with experience of families having ‘ulterior motives’ worked with users of mental health services.

**Separation of assessment from service delivery**

3.36 Policy and practice guidance makes clear that assessment should be a completely separate process from service delivery, and indeed the introduction of a
purchaser/provider split and development of a mixed economy of care, were key components of the community care legislation. Service managers were asked to what extent assessment was separated from service delivery. Some responded mainly in terms of departmental structures, some in terms of care manager activities but overall the responses indicate a very mixed picture across Scotland. In the majority of cases – 18 – there was said to be a partial separation of the two. This included a few authorities which had introduced a more extensive division in the early 1990s, but had since moved back to closer integration. For example, as we have seen, it was common for home care managers and OTs to carry out simple assessments and deliver services. While care managers were mostly responsible for assessment rather than service delivery, there were times when they also provided counselling and support on a one to one basis. Indeed in one authority which was only offering intensive care management, these activities were seen as an important part of the assessment process. The role of care managers in specialist teams appeared to vary considerably, with some being described as more separated from service delivery, and others as less, than care managers in non-specialist teams. Some service managers described the separation as partial in the sense that the authority used a mix of in-house and external services. Eight authorities reported that assessment was completely separated from service delivery. In one of these, home care did not carry out any assessments. In another, service providers, such as day care staff, played an important part in monitoring and review, but not in assessment. On the other hand, in six authorities there was no separation at all.

SUMMARY

3.37 The screening process is made up of a series of decisions: the findings point to considerable variation between authorities regarding the basis on which these decisions were made and the extent to which they were differentiated. A few believed it would be premature to decide on the complexity of a case at the point of screening, while others were making some decisions about services. Twenty one authorities reported targeting people with complex needs for care management at this stage. Most care managers worked to set criteria, but some relied on professional skills and experience. In some teams, seniors or team leaders were reportedly responsible for screening referrals, begging the question of whether this was a good use of their time and an effective way to screen. In contrast, elsewhere care managers attached to GP practices were the contact point for all referrals. In five cases, no-one was allocated responsibility for supervising screening, and 10 of the 17 care managers who were involved in screening had not been trained how to do it.

3.38 In 24 authorities, there was some differentiation between staff carrying out different levels of assessment, with qualified staff taking on complex cases. Most also had some degree of specialisation in terms of user group, particularly users of mental health services and people with learning disabilities. It was worrying to discover an apparent degree of confusion among service managers about single shared assessment tools, with a number of authorities wrongly reporting they were using one. Fifteen authorities are piloting shared tools, and one is about to extend use of a shared tool for all
user groups across the authority. Scotland has a long way to go to achieve comprehensive
use of shared tools for older people and those with dementia, as proposed by the Joint

3.39 There were many reports of the close involvement of health colleagues in the
assessment process, with 12 authorities accepting assessments carried out by NHS staff,
albeit often for simple services. Some difficulties were experienced obtaining specialist
assessments, however. The involvement of housing colleagues was at a much lower level,
with most only being consulted where a specific housing need was identified. There were
some examples of joint initiatives however. Only one care manager reported difficulty
co-ordinating different professionals’ contributions to assessment.

3.40 In most cases users and carers were described as closely involved throughout the
assessment process. Although all but one authority had some form of independent
advocacy, access to this was restricted in 18. Very little thought had been given to how
best to involve people from ethnic minority communities in assessment. About half the
authorities did not routinely offer carers an assessment of their own needs.

3.41 Finally, a mixed picture emerged regarding the separation of assessment from
service delivery. Eight authorities reported that these were fully separated, eighteen,
partially and six, not at all.
CHAPTER FOUR: CARE PLANNING, MONITORING AND REVIEW

INTRODUCTION

4.1 This chapter examines the care planning, monitoring and review stages of the care management process, again drawing on, and sometimes comparing, data obtained in the first part of the study from both service managers and care managers.

CARE PLANNING

4.2 The process of care management will not make a difference to users’ lives if a supportive financial and administrative infrastructure is not in place. In addition, Challis et al (1997) emphasise that in order to be effective, care management needs a ‘resource-rich context’, offering choice and individually tailored support. In this section we look at various aspects of that wider context.

Allocating services

4.3 Table 4.1 sets out the factors which care managers reported taking into account when allocating services. By far the most frequent was the requirement to target those users in greatest need: this is also reflected to varying extents in other responses – eligibility criteria, taking cases to a resource panel and the degree of assessed risk. However five care managers reported that there were no set criteria for making these decisions: it was a matter for individual judgement. This is reminiscent of the findings reported earlier about how decisions were made at the point of screening, when some authorities had written criteria while others were content to rely on professional judgement, or a mixture of the two. When it comes to allocating services however, it seems that a higher number of authorities required care managers to use specific criteria for making decisions. Eleven care managers reported that availability of resources was another factor influencing outcomes while individual circumstances, such as the user’s financial situation or personal preference, could also play a part. The ‘other’ factors cited were carer stress, the need to foster independence and, in an island authority, the availability of transport.
Table 4.1  Factors influencing service allocation (care managers)

<table>
<thead>
<tr>
<th>Type of factor</th>
<th>Frequency of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target greatest need</td>
<td>21</td>
</tr>
<tr>
<td>Resource availability</td>
<td>11</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>5</td>
</tr>
<tr>
<td>Resource panel</td>
<td>5</td>
</tr>
<tr>
<td>Degree of assessed risk</td>
<td>5</td>
</tr>
<tr>
<td>No set criteria</td>
<td>5</td>
</tr>
<tr>
<td>User/carer financial circumstances</td>
<td>2</td>
</tr>
<tr>
<td>Client preference</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

Devolved budgets

4.4 It will be recalled from Chapter 2 that only one authority in Scotland had devolved budgets to all its care managers. A few others reported that care managers had considerable decision-making authority in relation to purchasing. Elsewhere there was some degree of financial leeway but overall this appeared to be fairly limited. For example, care managers could negotiate with managers around individual packages. A few mentioned having access to other budgets, but again this sometimes involved team managers negotiating with other budget-holders. Others mentioned that they could apply for charitable funds on behalf of users but this is neither new nor specific to care management.

Costing care packages

4.5 Cost ceilings for individual care packages were said to exist in 19 authorities and not in eight. Rather worryingly perhaps, five care managers did not know if there were any limits or not. As Tables 4.2 and 4.3 illustrate, just under two thirds of care managers were aware of the unit costs of in-house and externally provided services, while just under a third had some knowledge of both. The numbers of those with no knowledge of either were small.

Table 4.2  Care managers’ reported knowledge of unit costs of in-house services

<table>
<thead>
<tr>
<th>Degree of knowledge</th>
<th>Frequency among care managers</th>
<th>Percentage of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>18</td>
<td>56%</td>
</tr>
<tr>
<td>Partial</td>
<td>10</td>
<td>31%</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 4.3  Care managers’ reported knowledge of unit costs of external services

<table>
<thead>
<tr>
<th>Degree of knowledge</th>
<th>Frequency among care managers</th>
<th>Percentage of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>21</td>
<td>66%</td>
</tr>
<tr>
<td>Partial</td>
<td>10</td>
<td>31%</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

Choice of provision

4.6 As Table 4.4 shows, about half the care managers did not think there was enough good quality provision locally to offer users a choice of ways of meeting need (as opposed to choice within a specific type of service). In relation to a choice of specific service, such as different forms of short breaks or home care, users were perceived as having even less choice.

Table 4.4 Degree of choice available to users: care managers’ perceptions

<table>
<thead>
<tr>
<th>Degree of choice</th>
<th>Choice of provision</th>
<th>Choice of specific service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good choice</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Some choice</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Insufficient choice</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Totals</td>
<td>32</td>
<td>32</td>
</tr>
</tbody>
</table>

4.7 A more detailed look at the data reveals, as would be expected, a fair degree of regional variation, with some authorities apparently struggling to offer choice to certain user groups, or meet particular needs. Nevertheless, some common themes emerge. Sometimes lack of choice was attributed to characteristics of the area, with several care managers from rural localities commenting on a lack of providers and care staff. On the other hand, this had led some authorities to encourage service providers to come into their area. For example one authority had worked with voluntary organisations to set up provision to fill identified gaps and a number of joint projects were now in place. Socio-economic factors could also stimulate the development of a lively private sector, with one care manager working in a relatively affluent area linking this to the range of private providers available locally. Conversely, less choice might be expected in disadvantaged areas, although this was not reported.

4.8 In general, although there were exceptions, care managers perceived more options being available to older people, while ‘younger disabled people’ (presumably meaning those aged 65 or under) had less choice. Other groups, which may not comprise large numbers but were identified as having few options, were people with dementia, head injuries or Korsakoff’s Syndrome. In relation to ways of meeting need, the data indicate that there was often some choice of buildings-based provision, with several care managers citing a number of residential or nursing homes.
4.9 The type of service in which least choice was available was short-term care. Although one or two authorities could offer a choice of respite within residential settings, in other areas there were few or no options. Domiciliary care was also seen as fairly restricted. A few care managers made the point that having a range of local providers did not necessarily guarantee a good choice. For example, one area had a number of private home care services but there was little variation in what they offered. Another felt that having a choice of providers within the mental health field was not particularly beneficial because, in her view, none of them had a good understanding of the relevant issues. Overall then, and although there were exceptions (some of which are discussed in chapters 6 and 7), care managers believed that users did not have enough good quality choices in care planning.

Restrictions on care managers’ access to services

4.10 Twenty-four care managers - 75% of the sample – faced some restrictions, imposed by the local authority, in accessing service providers. Fifteen were required to use in-house provision first and only where that was unavailable could they go to external providers. Fifteen had to work to a prescribed, or preferred, list of providers. However, it should be remembered that, while this can have a restricting effect, ‘good’ lists are also a form of quality control. Other factors which limited room for manoeuvre were a ban on spot purchasing or going outwith the authority’s geographical boundaries, pricing policies which were unacceptable to nursing homes, and having to access services through seniors rather than directly. Not having a devolved budget (perhaps the same point) was identified by two respondents as a restricting factor although arguably it was a good deal more widespread than that since, as already seen, nearly all the care managers were in that position. Taken together, these factors add up to a significant restraint on potential creativity in care planning.

Developing creative packages

4.11 For some people to be sustained in their own homes, support may need to be available twenty-four hours a day, on an on-going and emergency basis. Care managers were asked how far it was possible to achieve this. The main findings were:

- in no authority was 24 hour care reported to be always an option
- in 15 authorities, 24 hour care was available in certain circumstances, eg: short term arrangement or through the Independent Living Fund (ILF) or direct payments
- in 9 authorities, 24 hour emergency cover was generally available
- in 17 authorities, 24 hour emergency cover was available in some circumstances
- in 6 authorities, 24 hour care was not available either planned or in emergencies.

4.13 Authorities’ ability to provide round-the-clock support on an on-going basis was severely limited. Where this was available, it was often through the use of direct
payments or ILF funding. It was reported that 18 authorities had direct payment schemes and in most of these, recipients were allocated a care manager. Service managers indicated that the picture was a little brighter in terms of 24 hour emergency cover, presumably because this was a short term arrangement. The six authorities which could not apparently provide round-the-clock care in any circumstances must have been unable to sustain many people with complex needs in their own homes.

4.14 Similarly, service managers indicated that people with learning disabilities and users of mental health services were more likely to be offered long-term intensive support, and older people, much less likely. As one manager pointed out, hospital resettlement programmes have meant “we have had to do this”. However, the costs can be very high, leading another service manager to question whether his authority could realistically continue with care packages of over £140,000 per annum.

4.15 For older people, however, when it became more expensive to support individuals in their own homes than it would be to move them into residential or nursing homes, the data suggests that decisions are usually based on cost. One service manager, for example, stated

“once the costs of a home based package exceed the costs of a nursing home place we have to seek head of service approval to fund it”.

4.16 Another said that financial considerations could lead to a decision to “push people towards nursing homes”; a third, that the authority would “suggest” such a move. It would however offer “more” to a younger disabled person. With regards to housing, one service manager commented that housing agencies were disinclined to fund housing developments for older people. There are some exceptions to this: one authority reported that a recent survey had shown that it spent two thirds of the budget for older people on supporting individuals in their own homes. Home care could be provided three times a day, and a ‘goodnight’ service was available. Where people were terminally ill, care could be offered round-the-clock, seven days a week.

4.17 Given the constraints reported, care managers were asked how far it was possible to find creative ways of supporting people with complex or rapidly changing needs in their own homes. Nineteen reported that it was possible, three said it was not easy to do so and ten, that it was difficult. However, many of those who said it was possible also stressed that there were difficulties to be overcome. Some commented that while it was easy to think of creative solutions, it was harder to find ways of putting them into practice. A number of recurring themes emerged across the sample:

- lack of resources
- no devolved budgets for care managers
- inflexible services
- lack of transport to resources
- lack of direct access for care managers to service providers
- restrictive local authority guidelines and protocols
- service led culture within department
- waiting lists for services.

4.18 When asked to identify problematic aspects of care management, 21 care managers and 16 service managers identified financial considerations and lack of resources as the most problematic issue. Service managers most frequently described these difficulties in terms of a conflict between resources and need, and lack of adequate money to provide services. Care managers also expressed concern about the balance between money and need. In addition, some found their involvement in users’ personal finances problematic: several felt uncomfortable about conducting financial assessments.

4.19 While many respondents clearly felt that organisational and policy issues were largely outwith their control, a few believed that individual care managers could still make a difference – given the right approach. It was possible to find creative solutions if care managers had energy, commitment and a positive attitude. One commented

“If you start from the person first, it’s easy to be creative. If you approach someone as a risk, it can be difficult.”

4.20 At a practical level, one or two care managers stressed the use of self as a resource. However other care managers who had found it was possible to be creative in sustaining people with complex needs at home referred to specific budgets which allowed them to do so.

4.21 The respondent from the only authority in which all care managers had devolved budgets commented:

“Yes, I think it is [possible]. For example, a lady who was very confused was being looked after by a neighbour who could no longer do it. I purchased time from the Alzheimer’s Society for them to assess what was really happening.”

4.22 As reported earlier, some care managers had access to other funds, such as winter pressures monies, resource transfer, a service development budget and flexi-budgets. A care manager using resource transfer monies (his wording is a little misleading) commented:

“The fact that finance is held by the care manager allows a certain creativity. For example, I have encouraged a service provider to run personalised, individual respite programmes for users.”
4.23 Specific resources which had been used to sustain individuals with complex or rapidly changing needs at home included:

- rapid response team
- support workers
- relatives
- a range of home care providers, including an in-house emergency service
- church befriending / bereavement schemes
- specific voluntary organisations
- offenders on community service.

4.24 Care managers were asked to give examples of ways they had helped particular individuals with complex needs to stay at home. Ten did so. Without wishing to appear critical of individuals’ practice, most of the examples given did not in fact appear to be particularly imaginative or flexible. For example, one concerned a young disabled mother who required help with toileting. To offer her husband a break, but avoid the woman going into residential short term care, she was given a mobile phone to summon a carer when she needed assistance. We were not told how long she might have to wait for help to arrive! Another example concerned a lady living alone supported by a team of carers whose needs suddenly increased dramatically to a point where she was unable to leave home without two-to-one support. The care manager was able to arrange part-time two-to-one support to allow the client to get out and about. However, she had to go back to the commissioning team in order to do this, and it was only agreed on a temporary basis. Some care managers gave examples of creative work with people in residential care in answer to this question.

**MONITORING**

4.25 Once the care package was in place, twenty-seven care managers kept in touch with their clients, at least for some time, while five did so in certain cases. In three authorities, in-house service providers would take on the monitoring role, but where external provision was involved, the care manager kept in touch. Table 4.5 shows how often care managers reported keeping in touch with users. Over half reported that they would do so as and when required, depending on the complexity of the case and the nature of the care package. The respondent who reported that contact could often be on a daily basis worked mostly with users of mental health services, while the care manager who visited weekly was from an early supported discharge team: her contact stopped altogether after six weeks.
Table 4.5 Potential frequency of monitoring packages as reported by care managers

<table>
<thead>
<tr>
<th>Frequency of contact</th>
<th>No of care managers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Weekly</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Fortnightly</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Monthly</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>6-8 weekly</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Quarterly</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>Bi-annually</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>Annually</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>As and when required</td>
<td>17</td>
<td>53.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

4.26 Care managers were asked what form this monitoring would take. Their responses are set out below: most care managers identified more than one type of contact, again often depending on the nature of individual circumstances. Some monitoring was of an indirect nature, with care managers keeping in touch with the user’s progress through family or service providers.

Table 4.6 Type of monitoring contact reported by care managers

<table>
<thead>
<tr>
<th>Type of contact</th>
<th>No of care managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits</td>
<td>30</td>
</tr>
<tr>
<td>Phone calls</td>
<td>25</td>
</tr>
<tr>
<td>Depend on case</td>
<td>13</td>
</tr>
<tr>
<td>Through service providers</td>
<td>14</td>
</tr>
<tr>
<td>Through families</td>
<td>3</td>
</tr>
<tr>
<td>Letter</td>
<td>3</td>
</tr>
<tr>
<td>User-initiated contact</td>
<td>3</td>
</tr>
<tr>
<td>Through meetings</td>
<td>1</td>
</tr>
</tbody>
</table>

4.27 Both care managers and service managers were asked who was responsible for ongoing monitoring of care managed cases. Table 4.7 shows that there were some differences of perception. Although a slightly higher number of service managers than care managers reported that the latter were responsible for ongoing monitoring, care managers were more likely to identify themselves as the only person with that responsibility. Service managers were more likely to see a number of people at different levels as having some responsibility for monitoring cases, including seniors, team leaders and, in two cases, senior management. These staff could be involved in monitoring through ‘spot checking’, supervision or as part of a wider service review.

4.28 The data suggest it is possible, although it cannot be concluded, that care managers played a more active or continuing role in monitoring than service managers appreciated, or thought appropriate. Another way of looking at the findings is that care managers felt they carried more responsibility themselves for monitoring than service managers appreciated. Overall, the data show a lack of clarity about who exactly is...
responsible for monitoring. If all those identified were actually doing it, then a disproportionate amount of time and effort is being spent on monitoring.

Table 4.7  Responsibility for ongoing monitoring: care managers’ and service managers’ perceptions

<table>
<thead>
<tr>
<th>Responsibility for monitoring</th>
<th>Care managers’ perceptions</th>
<th>Service managers’ perceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care manager</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>Seniors</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Team leaders</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Service managers</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Social work assistant</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Providers</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Health professionals</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Users/carers</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Varies by case</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Allocated to team</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

4.29 Service managers were asked what form on-going monitoring took. Their responses, set out below, are similar to those given by care managers (see Table 4.6) although the latter relates more to initial monitoring. More care managers carried out home visits than service managers apparently realised. Again, the more managerial perspective is reflected in a number of service managers identifying supervision, checks and quality control mechanisms as part of the monitoring process, none of which were mentioned by care managers. The latter saw users and carers as playing a bigger part than service managers apparently did but this probably reflects the care managers’ ‘on the ground’ experience.

Table 4.8  Forms of ongoing monitoring

<table>
<thead>
<tr>
<th>Form of monitoring</th>
<th>No of service managers reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits</td>
<td>21</td>
</tr>
<tr>
<td>Phone calls</td>
<td>12</td>
</tr>
<tr>
<td>Through providers</td>
<td>12</td>
</tr>
<tr>
<td>Through supervision</td>
<td>8</td>
</tr>
<tr>
<td>Letter</td>
<td>2</td>
</tr>
<tr>
<td>Quality appraisal</td>
<td>3</td>
</tr>
<tr>
<td>Case closure checks</td>
<td>2</td>
</tr>
<tr>
<td>Random checks</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

The ‘other’ category comprised monitoring through carers, service managers and case conferences.

4.30 Care managers were asked what happened when frequent amendments were needed to the care plan because an individual had complex or rapidly or frequently changing needs. The majority reported that they would increase their frequency of monitoring, become “more vigilant” as one said, and make amendments to the plan as
often as required. Several were working in this way with many clients and saw the need to be flexible and responsive as an integral part of the job. Most implied that amendments would be made to detailed arrangements without the need for an entirely new plan. The importance of good communication and information-giving between all involved – users, carers, care manager and service providers - was stressed by several. One described an information loop whereby, in a case where needs were rapidly changing, the care manager would expect extra feedback from service providers, adjust the care plan accordingly and inform the latter of the changes required. Five care managers suggested that, in these circumstances, a more formal review or series of reviews would take place, albeit one added that this would be called “very quickly”, while others identified a possible need to secure additional funding or new contracts. One care manager reported that “a whole new assessment” would take place, adding that it was sometimes better to start from the beginning again rather than “tinkering around the edges of a plan”. These findings suggest that while most authorities could react quickly to rapidly changing needs, in a few cases, the process was slower and cumbersome.

4.31 Again, care managers were asked to give examples of situations where it had been necessary to make frequent amendments to plans but only ten did so. One concerned a person who became very agitated after returning home from day-care, so the day care arrangement was extended to cover teatime. This person’s support needs continued to rise and so short-term care was offered for two days a week. For a while, this package was being extended every two days. A more unusual example focused on a mother and daughter who both had care needs: the daughter was taking care of her mother, supported by Section 12 payments, but the latter’s condition deteriorated until she had to move into a special dementia unit. In the meantime the daughter’s condition also worsened and another plan was drawn up for her support. Other care managers cited examples of people with terminal illness or older people living alone at some risk, where plans were changed on virtually a daily basis.

REVIEW

4.32 The guidance on assessment and care management states that reviews should be carried out regularly, by “someone who does not have a direct stake in the services provided” (SSI, SWSI, 1991, 2.29). The SSI review of care management in England found that many authorities were struggling to carry out reviews of all cases.

Aims of review

4.33 Service managers were asked to describe the aims of review in their authority. As Table 4.9 illustrates, the most frequent response was that review aimed to ensure that services used still met individual need. Reviewing the effectiveness of the care plan was also important (and perhaps not very different) although it may be a little worrying that only 12 service managers saw assessing user or carer satisfaction as an aim of review. On the other hand, it could be argued that most of the objectives identified are user-focused
with relatively few being more authority-focused, for example, only four respondents identified the need to consider value for money. Among the ‘other’ aims mentioned were sorting out problems, building on positives, planning for the next stage of care, re-assessing risk and receiving feedback from colleagues. Checking contract compliance was identified by one respondent.

Table 4.9 Aims of review (as reported by service managers)

<table>
<thead>
<tr>
<th>Type of aim</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure services still meet need</td>
<td>25</td>
</tr>
<tr>
<td>Review effectiveness of care plan</td>
<td>19</td>
</tr>
<tr>
<td>Check user/carer satisfaction</td>
<td>12</td>
</tr>
<tr>
<td>Identify any unmet needs</td>
<td>7</td>
</tr>
<tr>
<td>Assess quality of care</td>
<td>5</td>
</tr>
<tr>
<td>Review value for money</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

Are all cases reviewed?

4.34 Service managers from 20 authorities stated that all cases were reviewed. Several who reported that this was not the case added that it should be. One commented “That is our aim. I would like to say ‘yes’”; another said “the policy is yes. It is not always the case” while a third reported “We do not have the resources.” The types of cases which were not reviewed were usually classified as simple ones, although the definition of “simple” varied from all cases that were not “complex” to “very low level” packages, comprising one piece of equipment only. On the other hand, a care manager from one authority practising intensive care management said she would always carry out a review, “even if only one piece of equipment was involved.” In two authorities, some nursing or residential home placements were not reviewed. (There were also two missing answers to this question). One authority struggling to carry out reviews had introduced a system whereby providers carried out service reviews which included an ‘holistic look’ at some individuals. The results were fed back to the social work department, which had set a target of reviewing all existing cases themselves within three years.

Community based packages

4.35 Both service managers and care managers were asked how frequently reviews took place. Clearly considerable variation is to be expected regarding the frequency with which different cases are reviewed and this is reflected in the responses. Some respondents chose simply to say that reviews were held as and when required, depending on individual circumstances, while others identified the common, or stipulated, frequency, all other things being equal. What is perhaps less expected is the variation between the responses received from the two samples, set out in table 4.10. Over half the service managers, perhaps reflecting departmental polices, reported that reviews took place on an annual basis, while about a third, bi-annually. Only two reported that reviews
were held quarterly or more often. In contrast, eight care managers reported that reviews took place bi-annually, while only five (15%) reported reviews were held annually. Care managers’ responses suggest more flexibility and adaptability to individual users’ circumstances, with ten care managers, as opposed to three service managers, reporting that review were carried out as and when necessary. Overall the findings suggest that, in many authorities, while the policy may have been to have annual or bi-annual reviews, in practice they occurred more frequently. However, this must be seen in the context of at least 10 authorities not reviewing all cases.

Table 4.10 Frequency of review for community based packages

<table>
<thead>
<tr>
<th>Frequency of review</th>
<th>Service managers</th>
<th>Care managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>6-8 weekly</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Quarterly</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Bi annuallly</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Annually</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>As and when required</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

4.36 Care managers were asked who was responsible for calling reviews. Not surprisingly, in 30 cases the care manager was responsible, or mainly responsible, for calling reviews. In one authority where this was not the case, the ‘allocated worker’ was responsible. Here the care manager, although based in a community care team, worked closely with a multi disciplinary team and cases might be held by herself or another member of that team. The care manager who did not carry responsibility for calling reviews worked in an early supported discharge team (ESDT): although she did informally review her clients every week for six weeks, after that the cases were either closed or transferred on to the Home Care team or elsewhere for review purposes. Elsewhere, although the care managers held the main responsibility for calling reviews, other people could also do so if and when they thought appropriate. This could apply to users and carers, service providers, or “anyone involved in the case”. In two authorities, administrative staff were said to have some responsibility in that the computer system flagged up when particular cases were due for review.

4.37 With regard to carrying out reviews, again in most cases – 29 – the care manager was seen as wholly or mainly responsible. In the three authorities where this was not the case, one care manager reported, as above, that this was the “allocated worker’s” responsibility; one reported only that a review team carried out reviews of residential and nursing home placements (discussed in more detail below), and there was one missing answer. Service providers also carried out reviews, or carried some responsibility for doing so, in seven authorities and users in one. Four care managers reported that responsibility for allocating reviews fell to senior social workers or team leaders. In only one authority did the arrangements seem a little more ad hoc. This was a rural area which had recently introduced a car pooling scheme, whereby care managers could not claim expenses for using their own cars but had to book a council vehicle in advance. There were not enough cars to go round, so staff were informally sharing out reviews of nursing
and residential placements amongst themselves. Thus if one worker was driving to a particular home to review a client, and another worker had a client there who was also due for a review, one worker would conduct both reviews on the same visit.

4.38 In all cases, the care manager was involved in the review, be it a meeting or process, and carers and users were almost always offered the opportunity to participate (see below). In 28 authorities, all other relevant professionals would also be involved. Again, the vast majority of care managers reported that the form of the review varied according to individual circumstances. Nineteen reported that a formal meeting might take place, while in other cases, reviews took the form of home visits, phone calls to the user, carer and/or provider and occasionally, letters.

Residential and nursing home placements

4.39 In 27 authorities, there were some differences between reviews of community based and residential or nursing home packages. For the most part, the latter took place less frequently – usually annually once the resident was settled – although two service managers admitted that the main difference between the two was simply that people living in the community were more likely to be reviewed. In just under half the authorities, responsibility for carrying out reviews of residential and nursing home placements fell to a different worker or body from community based packages. Often the service provider was responsible, and gave feedback to the authority. Some authorities had appointed a review team or a single care manager with responsibility for carrying out all reviews within certain homes. In one case, “officers in the civic centre” were said to be responsible. Finally, one authority having difficulty meeting all its review commitments had introduced “paper reviews” for these placements.

Involvement of users and carers

4.40 Care managers were virtually unanimous in describing the user’s role as central to review. Users were asked to voice their opinions, give their views, comment on how well the current package was meeting their needs, make complaints and, according to one care manager, report any personality clashes. A few stressed that users could ask for a review at any time. In two authorities, users were said to lead the review if possible. However the extent of users’ involvement could depend on their ability or, according to one care manager, their personality. People with dementia and older people in acute hospital wards were identified as particularly hard to involve. Here care managers tended to rely on non-verbal communication or on carers to assess how the user was feeling. The importance was stressed of making the review meeting or process as easy as possible for the user, tailoring it to suit their particular needs and abilities. Only one care manager (working with people with learning disabilities) said that clients “may or may not” attend reviews: although users were asked whom they wished to be present, the review could not be based “solely on what they wanted”. One care manager believed that it was sometimes
important to meet users separately from their carers while another expressed the opinion that users’ views were more important than carers’.

4.41 Going on to carers, a more varied and qualified picture emerges concerning their involvement in reviews. While many care managers did seek carers’ views, and several described their role as “central”, “active” or “similar to that of users”, the point was frequently made that carers were generally as involved as they wished to be, and that much depended on their relationship with the user. While some were said to be assertive in demanding their rights, others were reticent about voicing an opinion. One care manager put it neatly: “Some act as a key worker; some act as a mere visitor.” As with assessment, some care managers conceptualised the carer as a resource to support the user: thus their role was described as advocate, expert, facilitator or information-giver, while others stressed the importance of reviewing the carer’s own needs for support. However some care managers were more wary of involving carers. Three only did so with the user’s agreement or, while carers’ views “were taken on board”, they did not “hold sway”.

Case closure

4.42 Finally, care managers were asked when they would close a case. The picture is a little cloudy because authorities have different policies in this regard, with some counting cases as ‘open’ which are only expected to involve an annual review, while others class these as ‘open passive’ and a few as ‘closed’ (for example, they may only be opened again when ‘called up’ by the computer for review). However Table 4.11 sets out the responses received: several care managers gave more than one answer to the question.

<table>
<thead>
<tr>
<th>Type of circumstance</th>
<th>No of care managers reporting it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive/ no further issues</td>
<td>15</td>
</tr>
<tr>
<td>When all is going well</td>
<td>9</td>
</tr>
<tr>
<td>Admission to hospital or long-term care</td>
<td>5</td>
</tr>
<tr>
<td>Transfer to another agency/ worker</td>
<td>4</td>
</tr>
<tr>
<td>On carer/client request</td>
<td>3</td>
</tr>
<tr>
<td>Objectives achieved</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
<tr>
<td>Some cases never closed</td>
<td>10</td>
</tr>
</tbody>
</table>

4.43 Among the ‘other’ reasons given were:

- the client had died or moved elsewhere
- only one service was involved
- no need to refer the user elsewhere
- pressure from seniors to close cases to aid caseload management.
4.44 It is worth stressing that ten care managers said there were some cases (and sometimes these were all the worker’s cases) which would never be closed because the user would always require continuing support. These were not all intensive cases however. None of the care managers in the three authorities described in chapter 7 as practising intensive care management kept cases open in this way. Here clients were more likely to be described as moving in and out of care management and thus cases would be opened, closed or held on a review system as appropriate to their current needs.

SUMMARY

4.45 Nineteen care managers were aware of cost ceilings for individual care packages, eight reported that none existed, while five did not know if they did or not. Just under two thirds of care managers knew the unit costs of in-house and external services while just under a third had some knowledge of both. Given the limited spending authority which most care managers enjoyed, however, these findings are less significant than they might appear.

4.46 About half the care managers did not think there was enough good quality provision locally to give users a choice of ways to meet need, and there was even less choice between types of service. Restricted options were attributed to various factors including rural and socio-economic factors. Although older people were seen as having more choice than other groups, in reality this was usually a choice between various residential or nursing homes. The type of service seen as offering least choice was short term care, while domiciliary care options were also fairly restricted. Twenty four care managers faced additional restrictions imposed by the authority which limited their access to a range of service providers. The extent to which round-the-clock cover could be provided to people in their own homes was generally very restricted, except where there was resource transfer funding or people had direct payments or ILF monies. These findings add up to a significant constriction on potential creativity in care planning: it is not surprising that when asked to give examples of creative packages for individuals, about two thirds of the sample did not do so and, where examples were given, not only had these often been hard to organise, they did not always appear particularly flexible or innovative.

4.47 Users were generally said to be closely involved in monitoring and review: carers tended to be involved as much as they wanted to be. Only 20 authorities reported that all cases were reviewed. As would be expected, there was variation in the frequency of monitoring and review, and the forms they took. Care managers and service managers had differing perceptions about these matters and about where responsibility lay. Overall there appears to be a lack of clarity surrounding not the aims of monitoring and review but how and when they should be carried out, with perhaps too much monitoring and too little reviewing taking place. Similarly, some care managers reported that certain cases would never be closed: these were not all intensive cases.
CHAPTER FIVE: TRAINING: CURRENT ARRANGEMENTS AND FUTURE NEEDS

INTRODUCTION

5.1 This chapter offers a detailed account of the training care managers and service managers had received in care management, existing training arrangements, and unmet training needs. It draws on both care managers’ and service managers’ accounts.

SKILLS, KNOWLEDGE AND EXPERIENCE NEEDED BY CARE MANAGERS

5.2 First, service managers were asked what skills, knowledge and experience care managers needed to have. This question evinced a very high number, and wide range of replies, clearly indicating that care managers are expected to be multi-skilled, highly competent and active in many areas. As Table 5.1 sets out, 16 different types of skill or knowledge were each identified by at least three service managers (usually many more) but the ‘other’ category contained a further 34 skills or areas of knowledge or experience which care managers might be expected to master. The front runner in all this was clearly the possession of good assessment skills, identified by 20 service managers. However if certain types of skill are grouped together, such as communication, negotiating, conflict resolution and relationship skills, it becomes clear that interpersonal skills, or as one respondent called them “people skills” was considered hugely important. The data also imply that, overall, having certain skills was seen as more important than possessing particular knowledge or experience, perhaps because the latter two could be acquired, while some of the more personal skills identified as necessary to care management might be less easy for some individuals to develop. However it was also important for care managers to be knowledgeable about certain matters, particularly the user groups they were working with, available resources, financial knowledge (departmental budgets, service costs and so on), and familiarity with relevant legislation.

5.3 It is sometimes interesting to note what respondents do not mention. Only two service managers explicitly identified the need for care managers to have an understanding of care management. Perhaps some took this for granted, while others identified the need for skills relevant to particular stages or aspects of the process, such as assessment, care planning, service co-ordination or joint working. The ability to focus on need, think laterally and take a holistic approach were also identified. Some also believed that care managers should hold a particular value base; they should be person-centred, non-judgmental, respectful of user choice and prepared to share power.
Table 5.1  Skills, knowledge and experience needed by care managers: service managers’ perceptions

<table>
<thead>
<tr>
<th>Type of attribute</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment skills</td>
<td>20</td>
</tr>
<tr>
<td>Communication skills</td>
<td>14</td>
</tr>
<tr>
<td>Financial skills/knowledge</td>
<td>13</td>
</tr>
<tr>
<td>Knowledge of particular user groups</td>
<td>12</td>
</tr>
<tr>
<td>Awareness of available resources</td>
<td>11</td>
</tr>
<tr>
<td>Organisational/co-ordinating skills</td>
<td>7</td>
</tr>
<tr>
<td>Ability to work jointly</td>
<td>7</td>
</tr>
<tr>
<td>Negotiating skills</td>
<td>6</td>
</tr>
<tr>
<td>Relationship/people skills</td>
<td>6</td>
</tr>
<tr>
<td>Knowledge of how other agencies work</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of relevant legislation</td>
<td>5</td>
</tr>
<tr>
<td>Conflict resolution skills</td>
<td>3</td>
</tr>
<tr>
<td>Knowledge of medical/physical conditions</td>
<td>3</td>
</tr>
<tr>
<td>Sound value base</td>
<td>3</td>
</tr>
<tr>
<td>Advocacy skills</td>
<td>3</td>
</tr>
<tr>
<td>Wide range of other skills (sic)</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
</tr>
</tbody>
</table>

PROFESSIONAL TRAINING

5.4  Care managers were asked how well they thought their professional training had prepared them for care management. (In one case, where the care manager had no professional training, this question was not applicable). As Table 5.2 illustrates, just over half felt it had done so very or quite well, while a smaller number believed it had prepared them not very well or not at all well. Although many of these respondents had undergone their professional training prior to the introduction of care management, they still felt some of the skills and insights gained at that time had proved useful in the new context. These included, for example, one care manager whose Diploma in Nursing Skills had taught her “a lot about assessment skills and taking a holistic approach to people’s problems”; another with social work training found that what she had been taught about liaising with people, family dynamics and dealing with stress was a useful basis for care management; a care manager with an occupational therapy background reported that her training had been a good preparation for taking a multi-disciplinary approach as well as giving insight into “the progress of illness and disability”. A couple of care managers based in CMHTs had found their training as mental health officers to be useful in care management. Among those who felt less well, or ill prepared by their professional training were a social worker who had no opportunity to study community care as an elective, another, with a CQSW, who felt her course had not sufficiently covered “the theoretical side of case management and the expectations of a case manager”, and several who felt that their training had done nothing to prepare them to deal with all the financial issues involved in care management.
Table 5.2  Care managers’ perceptions of how well their professional training had prepared them for care management

<table>
<thead>
<tr>
<th>Perception</th>
<th>No of care managers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Quite well</td>
<td>12</td>
<td>37.5</td>
</tr>
<tr>
<td>Not very well</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>Not at all well</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

IN-SERVICE TRAINING

Content and frequency

5.5  Both service managers and care managers were asked what training the latter had received in care management as part of their job (ie: arranged or funded by the authority). There is a danger that, taken at face value, the relatively high number of responses might indicate that there was a good deal of training on offer. Two service managers reported that care managers had received little or no training in care management, and while all the rest of the sample reported some training activities, these were often not specific to care management although it might be argued that all had some relevance to it. In fact, service managers tended to be a little vague about the content, sometimes described as “ad hoc” or “varies according to need”. In just under half the authorities (15) it was reported that care managers had received some training in aspects of the care management process. However, as discussed below, this was often some years ago. In two cases, this training had recently been, or was shortly to be, adapted to take account of intensive care management. Other topics identified included general induction, paperwork and procedures, “bureaucracy”, IT and, on a different note, values.

5.6  Most training had been provided in-house. Nineteen service managers reported that staff development events had covered topics of relevance to care management, and eleven referred to ‘on-the-job’ training. In two authorities, the departmental training section devised individual programmes for staff. Five authorities had commissioned training from external providers, for example, the National Development Team had provided training in Person Centred Planning for one authority. In 21 authorities (66% of the sample), some joint training with other agencies had taken place. Usually this was with health colleagues, in one case with housing, while three authorities reported that a number of agencies had been involved. Carers had taken part in delivering some training in ten authorities, and users in nine. A few authorities sent care managers on academic courses, such as a Diploma or Masters in Community Care. One respondent commented that there were no academic courses specific to care management but others reported they were either investigating, or had staff attending, a course on care management run by
Napier University, comprising four modules and leading to a post-graduate qualification. Some care managers had attended short courses on mental health officer training or dementia care while several mentioned that care managers attended relevant conferences. Other staff, such as community care or social work assistants, were able to study for HNCs or SVQs.

5.7 However many authorities also reported that their staff had not received any training specific to care management for several years. Several remembered the CC1 and CC2 training that had been provided by Dundee University with the introduction of care management in the early nineties: this was the only training some care managers appeared to have received. Some authorities which, prior to 1996, had been part of a larger regional council, identified the training provided by the latter as the only or the main training received. Only one authority reported that staff development events were held on a monthly basis, and another, every three months. However a number of authorities also reported that they were aware of the gaps in current training and were reviewing their programmes.

5.8 Turning to the care managers, eight reported that they had received no training in care management. As with the service managers, where they did report that training had taken place, this tended to be in somewhat unspecified terms, with several describing the content as “various” or “bits and pieces”. Eleven care managers had been given some form of introduction to care management – this was often the early Dundee University courses – and nine had been given some training in financial aspects of care management, such as budget management or conducting financial assessments. Other topics identified by a few care managers were screening, paperwork, welfare benefits and input about specific conditions such as dementia. A number of other subjects, most of which were not specific to care management, were each identified by one care manager – legislative, IT training, eligibility criteria, risk assessment, carer awareness, person centred planning, caseload management and the use of CarenapD.

5.9 Service managers were also asked what training they had received in care management. Nine had not received any, one commenting that he learnt through experience. Others reported that their training had been similar to that available to care managers, although the data shows they were much less likely to have been offered on-the-job training (perhaps because they had been responsible for delivering it, as one explicitly said). As a group, service managers had also attended fewer staff development events relevant to care management. Ten reported they had received some training in aspects of the care management process, and one in intensive care management. The others had been trained in management skills, budgetary skills, negotiating skills, legislation or about specific community care groups. Again a number had gained academic qualifications relating to community care.

5.10 We also asked if administrative staff involved in the care management process had been offered any training. In ten authorities, the answer was ‘none’. Five service managers reported that administrative staff had been trained in IT skills, four in screening, four in financial matters and four in general administrative duties. One
referred to training in customer care and reception duties. Only two identified training more specific to care management, one reporting that the authority drew from the practice guidance on assessment and care management when planning training for administrative staff, another that support staff were encouraged to attend the same training as care managers, since they were an integral part of the process. Most of the training was provided in-house, although two authorities had bought in some sessions from external agencies.

5.11 Thirteen authorities had carried out, or commissioned, some evaluation of the training they identified as relevant to care management. Most of this was conducted in-house, comprising either written evaluation sheets completed by participants or else small scale evaluations carried out by their training section. Three authorities had commissioned external evaluations, in one case from an academic body and in two, from voluntary organisations.

Perceived usefulness

5.12 Care managers and service managers were asked how useful or effective the current training was. As Table 5.3 shows, fairly equal numbers in each sample believed it was ‘very effective’ although, overall, care managers were more positive about the training than were service managers. Where people reported the training had ‘mixed’ usefulness, this was either because one part of it had been effective and another, less so, or because what was available had been good, but there was so little of it that, overall, the training could not be described as effective. Twelve care managers did not answer this question because they had not received any training specific to care management for several years, nor did four service managers who said none was currently provided in their authorities. However, others who did answer these questions were not necessarily receiving or providing training specific to care management.

Table 5.3 Perceived effectiveness of training

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>No of care managers</th>
<th>Percentage of care managers</th>
<th>Number of service managers</th>
<th>Percentage of service managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very effective</td>
<td>9</td>
<td>28%</td>
<td>10</td>
<td>31%</td>
</tr>
<tr>
<td>Fairly effective</td>
<td>7</td>
<td>22%</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>Mixed</td>
<td>4</td>
<td>12.5%</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>Not very effective</td>
<td>0</td>
<td>0%</td>
<td>7</td>
<td>22%</td>
</tr>
<tr>
<td>Don’t know/under review</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>N/A (no training)</td>
<td>12</td>
<td>37.5%</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100%</td>
<td>32</td>
<td>100%</td>
</tr>
</tbody>
</table>

UNMET TRAINING NEEDS

5.13 Both service managers and care managers were asked to identify the latter’s unmet training needs. Again, this question generated a very long list of responses, which
are detailed below. There was great diversity in respondents’ perceptions. The unmet training needs identified most often concerned knowledge about the law, financial knowledge and skills, issues relating to specific user groups, and the roles and tasks of care managers. No topic was identified by more than 14 out of the 64 respondents. However, there was not a great difference between the two sample’s perceptions, although service managers were more likely to identify the need for financial training and care managers, for “general updates”, perhaps reflecting some anxiety about keeping abreast of all the recent and current changes in policy and practice. The first difference may be accounted for by the fact that, as we have seen, most care managers were not responsible for budget holding and therefore may not have seen this as a priority; the desire to keep abreast with policy developments may reflect the fact that care managers are not always given full information about these, (a point made during one of the case study visits) or, if they are, may not always have time to study them. Only three care managers did not think they had any particular unmet training needs at present: none of the service managers took that view.

Table 5.4  Reported unmet training needs of care managers

<table>
<thead>
<tr>
<th>Type of training need</th>
<th>No of care managers reporting it</th>
<th>No of service managers reporting it</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative changes</td>
<td>7</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Financial</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Specific user group issues</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Care manager role/tasks</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Assessment skills</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>General updates</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Management</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Professional training</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Intensive care management</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>IT</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Negotiating skills</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

5.14  It is interesting to note that six care managers and six service managers identified a need for training about the roles and tasks of care managers. There was criticism that the new skills required for care management had not been taught. Most described this in quite ‘basic’ terms, almost as something that needed clarification, with one care manager, for example, reporting that he had drifted from social work into care management without any real guidance about how to do it. However a few service managers saw their staff as already very experienced and skilled and talked about the need for more specialised, in-depth training that would not ‘patronise’ practitioners. Not surprisingly, then, there is a need for different training programmes aimed at staff with different levels of experience, skills and knowledge. As some respondents recognised, this training will have to take account of intensive care management, as the Scottish Executive intends.

5.15  Various other unmet training needs were identified by the sample. Those listed below were each mentioned by only one or two respondents:
• more formal induction courses
• networking skills
• working collaboratively with carers
• awareness of health agencies’ structures
• liaison with other agencies
• how to meet needs innovatively
• managing limited resources
• recording unmet need
• risk management
• planning and developing resources
• physiotherapy/OT skills
• time management
• welfare benefits
• direct payments/ILF.

5.16 No respondents identified a need for training in screening referrals, despite the fact that 10 of the 17 care managers in the sample who were involved in screening had not been trained to do it. Findings presented earlier in this report suggest that many care managers would also benefit from training in care planning.

5.17 Finally, care managers were asked how their training needs could best be met. The point made most often, strangely perhaps given the general paucity of training, was the need for follow-up and refresher courses, having time to reflect on and consolidate what had been learnt. The importance of joint training was stressed by several: this was also identified as a priority by a number of service managers. Some thought that joint training would help standardise roles across disciplines for care managers and inform professionals about resources available in other agencies. While some care managers preferred in-house courses, others wanted to have training outwith the department, for example, in an academic setting. Three care managers found informal, professional forums were often the most useful way to learn, providing an opportunity to exchange ideas and experiences with colleagues.

SUMMARY

5.18 Managers had high expectations of care managers in terms of skills, knowledge and experience. Assessment and ‘people’ skills were seen as the most important attributes, with knowledge of resources, finance and legislation also being important.

5.19 Just over half the care managers felt their professional training had been a good preparation for care management, while a smaller number did not. This was not related to discipline. Eight care managers reported they had received no in-service training in care management. Both service managers and care managers tended to be vague about the content of training. Just under half the care managers had been given some input on aspects of the care management process but this was often several years ago. In 21 authorities, some joint training had taken place. Care managers tended to be more
positive about the usefulness of the training received than were service managers. Despite the fact that they were responsible for care management in their authorities, nine service managers had not had any training in it and, overall, service managers had received less training than care managers. Two administrative staff had received training specific to care management.

5.20 A long and diverse list of unmet training needs among care managers was identified. Those most often mentioned were law, finance, specific user group issues and care manager role and tasks. The research findings suggest that screening and care planning should also be considered. There is a need for different levels of training to suit differing needs and levels of experience.
CHAPTER SIX: CASE STUDY VISITS: SCOTTISH BORDERS AND MORAY

INTRODUCTION

6.1 As explained in chapter one, the original plan for the case studies was to select five or six authorities, each showing evidence of five specific good practice features. An initial analysis of both sets of questionnaires revealed that no one authority claimed all five features. However, based on the findings and some discussion with SWSI, five authorities were selected for further study. Their approaches to care management, although differing in many respects, each appeared to have certain good practice features. These authorities were Clackmannanshire, Scottish Borders, Inverclyde, Aberdeenshire and Moray. Interestingly, all but one was a rural area and the group also included two of the smallest authorities in Scotland. This chapter presents two of the five case studies - Scottish Borders and Moray. They are presented together because both authorities have undergone reorganisation of their care management systems since 1997 and both offer some form of care management to all community care clients. In contrast, the three authorities discussed in Chapter 7 target care management at people with complex needs.

SCOTTISH BORDERS

6.2 The Scottish Borders is a very rural area with no main town. The population is becoming older, and includes the highest proportion of retired people and those aged over 75 of any Scottish authority (SWSI, 2001). Unemployment is lower than the Scottish average but so are average earnings. Community care services are provided by the Department of Social Work.

6.3 Scottish Borders was selected as a case study area for three main reasons. During initial interview, the following good practice features were identified:

- well established multi-disciplinary working, including nurses employed by the NHS trained and working as care managers
- use of a single shared assessment tool, which had been piloted in two areas
- joint training with health, involving users and carers.

6.4 During our visit there, we met with a senior social worker/team leader who was responsible for a partnership pilot, a district nurse, a nurse co-ordinator, a community psychiatric nurse (CPN) based in a CMHT, a palliative care nurse based in a general hospital, and a social worker. All these staff acted as care managers where appropriate. Unfortunately, arrangements to meet a user and a carer were cancelled at short notice. The arrangements described below are mostly those within the Hawick pilot scheme, which were about to be rolled out across the authority.
Background

6.5 When care management was introduced in 1993, the Scottish Borders had taken it on as a task to be carried out alongside other duties. Some early work was done in two pilot projects, one of which sought to develop a multidisciplinary core group for assessment of older people referred by four GPs. However, despite some positive evaluations, (for example, Taylor, 1993) these early pilots were not continued and assessment, along with the rest of the care management process, had come to be seen as primarily a social work task. After several years operating this system, a decision was taken to review care management.

6.6 This review, funded through the Better Government for Older People project, took about a year and was overseen by a senior social work manager. It was undertaken in conjunction with health colleagues and involved user and carer consultation, reviews of current practice and research into care management arrangements in other authorities. When the process was nearing completion, a document called “10 Options for Change” was produced. A one-day conference, chaired by Professor David Challis, was convened to discuss these options and as a result two possible models of care management were selected for closer examination – the integrated and the partnership models. The former involves colleagues from different disciplines being located together in multi-disciplinary specialist teams, the latter involves colleagues working closely together, but remaining in separate teams.

6.7 The integrated model would have required a large amount of organisational and structural change. Budget control was also seen as potentially problematic whereas, in the partnership approach, financial arrangements were seen as more manageable. Another perceived difficulty in the integrated model (which was also brought up in Inverclyde) was that the increasing trend towards linking care managers to GP practices was incompatible with the trend towards locating them in specialist teams, which could not easily be GP linked.

6.8 The final decision was to adopt the partnership model of care management, whereby community nursing staff are trained in care management and able to access social care services on the same basis as social worker care managers. Pilots were set up, again in Duns and Hawick, in 1999 and completed in March 2000. These were independently evaluated and, at the time of writing, a modified version of the partnership model of care management is about to be rolled out across the authority.

6.9 When the pilots were introduced, we were told, there had been some initial apprehension: nurses could see only the time management implications of the extra workload while social workers were worried about the consequences for their role if nurses were to ‘take over’ care management tasks. In fact there has not been a vast increase in community nurse workloads: in Hawick only 25 cases are currently being managed by health staff.
6.10 A considerable amount of training was undertaken on the introduction of the pilot schemes: some criticism was made of the “heavy burden” of training and the cumbersome nature of the documentation provided to staff. During the eleven months of the pilots, the social work department freed up a senior social worker in each pilot area to act as an advisor to nursing colleagues. During the first three to four months, he acted as a first point of contact for nurses unsure how to implement the new arrangements. The nursing staff felt that this arrangement had worked very successfully.

6.11 Across the authority, there are now 65 staff acting as care managers, including 10 employed by NHS Trusts. Forty-five are based in the social work department, 10 in primary care settings and 10 in hospitals. The majority are from a social work background, but 10 have a nursing background and five are OTs. Care management was described as a task and all community care clients are ‘care managed’. The authority reported it was working on a definition of ‘intensive’ care management but was also waiting for clarification from the Scottish Executive regarding the latter’s definition of the term.

**Partnership Approach to Care Management**

6.12 The point was made that joint working had started from a good base in the Scottish Borders as staff had good collaborative relationships before the partnership model was introduced. Although the authority covers a large geographical area, the population is distributed quite sparsely and the various professions involved in community care knew each other quite well already.

6.13 District nurses, social workers, CPNs, and palliative care nurses work alongside one another as colleagues rather than working together in multi-disciplinary teams. It had originally been envisaged that staff from the community hospitals and health visitors would also act as care managers. However, that proved difficult because those staff do not hold on to cases in the same way that community nurses and social workers do: the question of who would then be responsible for monitoring and reviewing cases could not be resolved.

6.14 Within the partnership model of care management, the appropriate care manager will often be someone who is working with the user already. For example, if a CPN is already supporting someone with dementia and a need arises for social care intervention, the CPN can decide to care manage the case rather than having to ask a social worker to reassess the person. The CPN would carry out the assessment using the shared assessment tool (see below) and would then present the case for the necessary package of care to a senior social worker.

6.15 Originally it was envisaged that district nurses would deal with the simpler care management cases with which they were already familiar. However, it became obvious early in the pilots that district nurses were closely involved with a number of longer-term
and more complex cases, primarily young disabled people, for whom they were the obvious care managers.

6.16 Nurses do not undertake financial assessments. This is still done by local authority staff but not by professional social work staff. There is also a welfare benefits officer who aims to maximise benefits for users and helps with completing benefits forms.

6.17 One advantage of the partnership approach compared with previous arrangements was said to be that nurses are often in closer contact with users and may be in and out of a house two or three times a week. Therefore it is easier for users to express any concerns they have about their care package. Another advantage was said to be that response times are much quicker, one level of bureaucracy has been taken away and the problem of over assessment has also been addressed. It was agreed that staff on both sides now have a better understanding of how each authority operates and that health staff have a clearer picture of the local authority funding process. Thus, although they might still feel frustrated when a service requested could not be provided, or there was some delay in providing it, they had a better understanding of the underlying reason. The joint training and work shadowing which had taken place at the beginning of the project were also seen to have been useful in clarifying respective roles.

6.18 The palliative care nurse said that care management had made a very significant difference to her client group. In palliative care, speed in setting up care arrangements can be essential. Prior to the introduction of partnership care management, when the palliative care nurse had to liaise with social workers to set up packages, there were often delays, particularly over the weekend. Now she has immediate access to service providers and can have a package of care in place within hours. The palliative care service has its own funding and does not need to wait for approval by the eligibility panel (see below). To be eligible for palliative care, users had to have a DS1500 certificate.

6.19 Staff were asked if there were any disadvantages to the partnership approach. Health staff did not explicitly object to the extra paperwork but they did place a good deal of emphasis on this aspect of care management, to the extent that the whole process sometimes seemed to be viewed in terms of paperwork. However, the point was made that this drawback was outweighed by the ease and speed with which healthcare staff could now access social care services.

Single Shared Assessment Tool

6.20 As part of the pilot, a better, more streamlined assessment tool had been devised. The new care management assessment form is still a local authority document. Although community nurses use it in the same way as social workers, it does not replace or do away with the need for any nursing paperwork. The pilot evaluation indicated that further improvements could still be made to the form and it has been improved for the roll out of the pilot.
6.21 In the nurses’ view, the joint assessment tool has been an advantage. They made the point that medical assessments had often been carried out prior to a user becoming eligible for care management and that information from these could be used again. The two assessments did not have to be completed at once. Thus far their care management caseload had not been high: on average they were picking up no more than one case a week. It was felt that if these numbers became “too high”, community nurses might begin to resent the extra demands. However, the pilot projects had been set up so that nurses only took on a care management case if they agreed they could manage it within their workload. There was enough flexibility to allow users to switch between health and social work care management.

6.22 When the care plan has been approved by the eligibility panel (see below), a copy of it, but not the related social work paperwork (which might contain confidential information), is left in the user’s home. It is therefore available for nursing staff to look at, comment on and discuss with the user.

6.23 The social work and NHS Trust IT systems are not currently compatible, so health staff cannot access careplans on line. Nor can they input assessments directly onto the social work system. There are plans to replace the social work system but it was unclear if any thought had been given to whether the system should be accessible by health staff.

To target or not to target?

6.24 The care manager interviewed in the first part of the study had the highest number of care managed cases of any respondent – 117. The senior social worker later commented that many of these would be ‘service’ cases, requiring only annual review. However this social worker also reported that 42 of these 117 cases involved intensive care management. As this indicates, while everyone is care managed, there are different levels of care management. Although a user requesting a straightforward service is offered the whole care management process involving assessment, care planning, service provision and review, this should not take the same form as a complex case. Different levels of priority arise from the screening process: clients deemed to be an immediate risk to themselves or others would be seen immediately, less urgent cases would be assessed within one to five days, while up to three months would be allowed for responding to those accorded lowest priority. Some assessments could be done over the phone and reviews conducted less frequently.

6.25 Although clear written guidelines on the prioritisation of cases do exist, there were some indications that a differentiated approach may not always be applied systematically. One of the nurses suggested that in most cases a referral to social work was an indication that someone would eventually require a more extensive package of care. Thus, it was argued, a full assessment at an early stage might save time later. The social worker interviewed in the first part of the study suggested that care management could become “overwhelming” if offered to everyone. He believed that the numbers
receiving it should be reduced. In his estimation, almost half those currently receiving care management had approached the department for a specific resource, such as home care or meals on wheels, and neither wanted nor required full assessments and continuing reviews.

6.26 Unqualified Community Care Assistants (CCAs) are responsible for doing simple assessments and co-ordinating basic packages of care. They are not expected to deal with complex cases: because there may be risks associated with keeping some people in the community, it is not considered fair to expect unqualified, lower paid staff to assess these risks and bear responsibility for allowing a user to face them. Only qualified staff, who have had training in care management, carry out complex assessments. If cases prove to be more difficult than they appeared at first sight, they are passed on to a professionally qualified social worker.

6.27 The social work staff said they were waiting for more information from the Scottish Executive on intensive care management. A post had been created in the social work department to consider all the proposed changes in community care including the report of the Joint Future Group. Staff on the ground were waiting to hear the practical implications of policy decisions.

Eligibility Panels

6.28 There are weekly eligibility panels for requests for short-term care and home care. There are also panels for residential and nursing homes. The panels are made up of three senior social workers and three locality managers. Each of the three locality teams hold short term budgets, access to which can be authorised by a senior social worker to “tide teams over” until the panels meet on a Wednesday. As mentioned above, the palliative care service has its own budget and can commission home care directly. The dementia home care budget is also managed separately.

6.29 The panels were primarily seen as a way to ensure equity of care throughout the authority. Two years previously, home care budgets were at risk of being significantly overspent: the home care and residential panels were intended to ensure better budget management (although the residential panel had been operating for six or seven years), as well as equity across the region.

6.30 It was reported that very rarely are proposed home care packages turned down. However, this was apparently because care managers accepted that it was no good putting to the panel any case which did not adhere strictly to the eligibility criteria. Cases accepted by the panel for residential or nursing home care were likely to have to go on a waiting list, because frequently a person’s home of choice does not have any vacancies.

6.31 We asked staff whether having to refer proposed packages to an eligibility panel stifled creativity in drawing up care plans. On the whole they did not think so, but sometimes there was an impact on response times. The social worker interviewed during
the first part of the study reported that resources were well managed in the Borders. He believed that the panel process allows priorities to be set fairly.

Training

6.32 Staff in the Scottish Borders have undertaken a good deal of training in care management in recent years, unlike many other authorities. Most of the training was directly linked to the introduction of the new system, with two external training consultants having been brought in to provide joint training to health and social work staff. As mentioned above, some of that training was seen by health staff as unnecessary and even unhelpful. There had been a perception that the local authority was trying to impose social work values on health staff: the latter had their own professional values which, it was felt, were not being recognised. There was also some criticism that the training had concentrated too much on values and assessment and not enough on the practicalities of putting together a care package. Much of the criticism levelled at the early training had been accepted by social work managers. The training to be provided with the rollout of the pilots had been broken down into smaller blocks and concentrated on the practicalities of care management – how to make things happen.

6.33 The training which staff were most enthusiastic about was job shadowing, which had taken place as part of the introduction to the pilots. Staff on all sides felt this had given them a far clearer view of other professionals’ roles and the problems they had to face.

6.34 Unqualified staff had been included in the training. In the past, unqualified staff had been offered support to undertake professional training. This was no longer available and concern was expressed that these staff would leave the authority unless there were clear opportunities for promotion to qualified social work.

Conclusion

6.35 The Scottish Borders had put considerable time and effort into reviewing how care management was working and in drawing up their pilot projects. There is much evidence of good joint working and different professionals seem to co-operate well together. Joint training has helped increase mutual understanding of each other’s roles and responsibilities, as well as better appreciation of some of the difficulties faced by each profession. The joint assessment tool has proved acceptable to health staff although it has created some extra work, since it does not replace existing documentation. Indeed, there was some sense of professionals tending to think about care management in terms of the pieces of paper that had to be filled in. However, the major advantage to health staff of working as care managers is the ease and speed with which they can now access services for their patients and set up a package of care.
6.36 All community care clients are ‘care managed’. One problem arising from this, which we had identified before visiting the authority, was the large caseloads which social work care managers are expected to carry. This issue had also been identified in the authority’s own document “10 Options for Change” and it seems strange that it was not addressed in the changes which were eventually implemented.

6.37 Another issue identified in that document, and in the initial interviews for this study, was difficulty carrying out regular reviews of all packages. We were told that this problem was being addressed and various solutions were being considered, such as having one reviewing officer for those in residential and nursing care, or those who are well settled in long term care being reviewed by providers. No conclusions have been reached as yet.

6.38 The eligibility panels were not seen as a rubber stamping process but primarily as a means to ensure equity across the authority. The home care panel had forced staff to adhere strictly to eligibility guidelines. However, care managers in other areas without panels seem able to work to strict eligibility criteria as long as these are clearly drawn.

6.39 Finally, the Borders has a relatively comprehensive training programme for care management which staff found useful and which was replicated in few authorities.

MORAY

Introduction

6.40 Moray is another predominantly rural authority. It has the eighth largest land area of all Scottish authorities but in terms of population density, it is the fourth smallest (SWSI, 2001). Poverty indicators are low. It is expected that the population of older people will increase by 25% over the next 16 years, which will clearly place extra demand on community care services (SWSI, 2001). Social work and housing are co-located in a Department of Community Services.

6.41 Moray was selected for a case study because initial interviews suggested evidence of:

- good joint working, with some care managers located in primary care
- integration of home care and community nursing
- a pilot single shared assessment tool
- access to a range of service providers and creative packages of care.

6.42 During our visit, we met with a group of social work managers and then with a group of care managers, called community care officers. The managers’ group consisted of the head of community care services, the head of planning and commissioning in community care, a senior community care manager and two area managers. The
community care officers came from an area team, the older peoples’ psychiatry team, the learning disabilities team and the Forres pilot for joint working. We also visited three service users in their own homes.

General Approach to Care Management

6.43 Like the Scottish Borders, Moray has undergone a review and reorganisation of its community care services recently, completed in 2000. Until 1998, Moray employed a specialist team of care managers. Each was located by GP practice but managed centrally. Service managers reported that working in this way with GPs had proved useful, so it was decided to build on it post-review. Care management was a process aimed at relatively few people, all with complex needs. After the review, a decision was reached that care management should no longer be targeted in this way but should be available to everyone requiring care in the community. Moray has also moved away from the “role” model of care management, which it used to have in its generic community care teams, to the “task” model. This was described as a move from “the pure assessment, commissioning role of traditional care managers to a mix of the traditional role and the provision of direct services to the client.”

6.44 All community care clients are now offered full assessment and care management of their case, along with regular reviews. Stable cases are pooled for review purposes and may not be reviewed by the same worker who set up the care package. It was reported that caseloads were relatively high. However, the community care officer who took part in the first part of the study had 31 cases, 17 of which she described as complex. This compares well with the average in that sample.

6.45 Following re-organisation, there are four community care teams co-terminous with primary care teams, and workers are linked to specific GP practices. The four area teams comprise community care officers, community care organisers (home care supervisors) and OTs. A community care officer (learning disability) and community care officer (old age psychiatry), though not direct members of the team, link in to this arrangement. The mental health team is based at the local hospital, the old age psychiatry team in Aberlour and the learning disability (health team only at present) in Elgin. All these specialist teams are multi-disciplinary but have a direct link to the geographical teams.

6.46 Discussing the rationale behind the recent changes, the managers’ group reported that there had been inequities in the previous system of care management. It had been very much “an icing-on-the-cake service” available to a fortunate few (there had been about 200 care managed cases as opposed to 1500 home care cases). The referral route by which a case came forward determined the level of service users received. Whether they received a care management ‘service’ or a much more basic home care service depended on decisions taken at a very early stage in the assessment process. Many referrals came through home care, which also at times carried complex cases. The managers believed that, as a result of re-organisation, “every case can now be effectively care managed”.

76
6.47 Under the previous system, budgets had been devolved to individual care managers but there had been problems controlling it. Managers pointed out that this difficulty was partly related to the level of financial information workers received and partly to the level of demand. At the same time, it was reported that other staff within the department who were not involved in care management had felt some resentment at what was seen as the “élitist” activities of those with devolved budgets. It is worth adding that similar resentment about the spending powers of a Rapid Response Team was noted elsewhere. The community care officers saw things rather differently. In their view, the decision to move to a less targeted service had much to do with taking central control of budgets. However, managers reported that staff ‘on the ground’ had been members of the Review Group and decisions were based on their recommendations.

6.48 The decision to care manage all community care clients had brought with it implications for staffing. Community care officers no longer have to be professionally qualified, although they are expected to be experienced in community care and have at least an HNC/SVQ3. The policy is that senior practitioners, who must be qualified, will generally manage more complex cases. If a community care organiser begins managing a case which turns out to be complex, it is the responsibility of senior community care officers to ensure that the unqualified worker is adequately supported. The managers argued that someone with a lot of experience may also have the ability to deal with complex cases if supported. During the initial interview, the senior community care officer also suggested that a mix of cases meant that all staff gained experience in a variety of work.

6.49 However, data obtained from the community care officers during the study visit indicated some difficulty translating these policies into practice. In their view, there should have been greater differentiation between the activities of unqualified and qualified staff. This was partly related to the fact that qualified staff are on the same pay rates as unqualified workers (although there are pay barriers for unqualified staff). In addition, community care officers reported that unqualified staff sometimes struggled to deal with complex cases which community care officers would be better placed to tackle. They felt that their professional training enabled them to take a more holistic view of the user and “dig deeper” to discover any underlying issues. Qualified staff were also expected to take on some simple cases: one senior community care officer reported that he sometimes felt frustrated spending time on these.

**Budgets**

6.50 Following the recent review, the community care budget is allocated by geographical area. Every team now has an allocated resource. Community care officers cannot ‘spend’ without authorisation. Eligibility is determined by written criteria and approval for care packages given centrally. Approval for residential care placements and for complex packages is determined by a Needs Assessment Working Group (NAWG), which consists of hospital and social work staff at a senior level, from the Local Health Care Co-operative (LHCC), the council and the acute trust. It reviews the current
position in relation to delayed discharges, those in the community awaiting placements and the movement of patients from acute to community hospitals and home. This includes placements for people with learning disabilities and users of mental health services, as well as frail older people.

6.51 Community care officers reported that very rarely had proposed packages of care been rejected. Some felt that there had been a lack of procedural and policy guidelines under the old care management system. Now that the whole system was clearer it was actually easier to get funding for packages. There were some comments about delays in approving packages, delays of up to seven days being cited. For simple packages, community care officers seek authorisation from seniors, a speedier process.

**IT System**

6.52 Community care officers enter users’ assessments onto the IT system and when they propose a simple care package they e-mail it to their area manager for approval.

6.53 At a higher level, some consideration has been given to aligning social work and health IT systems. A pilot project is under discussion under the auspices of the Modernising Government scheme to allow health and social work IT systems to talk to one another. The primary aim of the new system is to allow the public 24-hour a day, 7-day a week access to council services. This is being piloted in community care and is seen as a first step towards genuine e-government.

**Creative Approaches to Care Management**

6.54 Managers reported that, prior to re-organisation, the independent care management team had promoted diversity of provision and that a wide range of day services is available in the area, for example, for people with learning disabilities. Unfortunately the financial uncertainty caused by the budget crisis in 1998 had caused some problems for providers. However, it was reported that good pockets of service exist despite a lack of choice in rural areas.

6.55 Care managers identified problems in East Moray with a shortage of carers and only two service providers. As in many other authorities, they believed it would be easier to come up with individualised care packages if more funds were available. Again, more flexible packages were easier to arrange for people being discharged from long-term hospital care because of resource transfer funding.

**Joint working**

6.56 Moray has a strong history of joint working. There is a close relationship with the coterminous LHCC, and a considerable amount of joint planning and working through
various projects. At management level there are contacts through the NAWG (described above) and through joint planning at senior level. On the ground, home care and community nursing are working co-terminously in Forres as part of the pilot, and it is intended to extend this arrangement throughout the authority. As part of this development, community nurses have been involved in training home carers, with the latter visiting patients in hospital prior to discharge. Social work and OT services are soon to be aligned into a single arrangement.

6.57 A pilot project for joint working has been on-going for a year in Forres, where the community care team, co-terminous with primary care, works alongside a multi disciplinary team based in a health centre. (Moray intends to base all its community care teams in joint accommodation eventually but there have been difficulties finding suitable premises). The Forres pilot centres on an integrated assessment process whereby any team member, including a health professional, can carry out an assessment and make decisions about care packages in conjunction with the social work area manager. Roughly 50 per cent of assessments are done by community care officers, 25 per cent in hospital prior to discharge, 20 per cent by physiotherapists and OtS, and about 5 per cent by community nursing staff. Clients are asked for permission to share information between professionals. The next step in the pilot was to consider how to move towards shared locality management, with a joint budget managed locally. This was planned for Autumn 2001 in Forres, rolling out to other areas of Moray later in the year.

6.58 An assessment tool used in the Forres pilot was devised locally and is used by all professionals. This form has proved so successful that other area teams have picked it up and are using it – however, in these cases it is being used by community care officers, not as a shared tool.

6.59 The learning disability team which, when we visited, was on the point of being reformed after being dispersed to area teams, had just finished developing a joint assessment tool. It was envisaged that this tool would allow the team to access services more easily. The older peoples’ psychiatry team was also looking at a specialist assessment tool, which might form part of the assessment process.

Visits to Service Users

6.60 We visited three service users in Elgin. One was a frail older lady living alone and the others were an elderly couple, both in poor health.

6.61 Both sets of users reported they were very satisfied with the services they were receiving. Neither package was complex: both were getting home care and meals on wheels and both were very complimentary about the standard of the home care service. They were full of praise for the home carers, who were seen as offering practical and emotional support ‘above and beyond’ their job remits.
None of the users could name their social worker/community care officer although both reported they knew someone to contact if they needed to. The users could not recall being given a community care assessment but, when prompted, did remember being asked a lot of questions about what they needed. As these were relatively straightforward situations, it may be that these users were now on an annual review system and no longer had a named community care officer.

**Conclusion**

Moray has put a great deal of effort into developing joint working with health and formalising links both at practitioner and policy level. This is evidenced through the Forres pilot project which has a reputation well beyond Moray for good collaboration. The single shared assessment tool developed there has proved an effective focus for joint work. Other examples of innovative collaboration include the alignment of both home care and community nurses, and OT and social work services. The authority is keen to further develop collaboration by introducing compatible IT systems for social work and health and improve access for the public through their e-government project.

The service users visited were more than satisfied with their care arrangements.

Community care officers argued for greater differentiation between the roles, tasks (and pay scales) of qualified and unqualified staff.

Service managers argued that offering care management to all clients ensured equity of provision. They believed that the new system in Moray was both more flexible and fairer than that envisaged in the Joint Future Group report.

**SUMMARY**

This chapter has presented the main findings from two of the case studies. The other three are set out in the following chapter, which also contains a summary of all five.
CHAPTER SEVEN: CASE STUDY VISITS: INVERCLYDE, CLACKMANNAN AND ABERDEENSHIRE

INTRODUCTION

7.1 This chapter presents the findings of the other three case studies, followed by a conclusion relating to all five.

INVERCLYDE

7.2 Inverclyde is another small authority but unlike Clackmannan it is predominantly urban. It has very high levels of deprivation along with a high incidence of drug and alcohol abuse. Almost half the population is dependant on welfare benefits. The population is expected to fall over the next 16 years by 16 percent, mostly among people aged 45 or under (SWSI, 2001). Community care is provided through a joint housing and social work department.

7.3 Following the initial interviews, Inverclyde was selected for further examination on the following grounds:

- A significant number of nurses employed by the NHS working as care managers
- A significant number of care managers based in multi disciplinary teams, hospitals and other diverse settings
- Formal links with housing officers in relation to assessment

7.4 During our visit to Inverclyde, we met with members of three multi disciplinary teams - the community mental health team, the rapid assessment team and the rapid response team. We also met with the Acting Service Manager (Community Care), a senior OT from the Rehabilitation Team and a housing officer who had been attached to the CMHT. We also visited two carers of service users.

General approach to care management

7.5 There are 62 workers acting as care managers in Inverclyde (although not all have that title), including 10 employed by NHS Trusts and one from a private agency. There are 16.5 posts located in the social work and housing department, 23 in primary care settings (although this does not include GP surgeries), 13.5 in hospitals and nine in other settings (local authority homes, day care, and drug and alcohol teams). Forty-four care managers come from a social work background, 11 from a nursing background and seven were formerly OTs. Care management is a task rather than a role. In some areas of activity, social work assistants carry out some care management tasks but in others, only qualified staff do so. The authority reported that of its present total of 1020 care managed
cases, all could be described as ‘intensive’. People receiving only home care or day-care do not receive care management.

7.6 Although staff told us that there was an Approvals Panel, which approved all packages of care, in practice this ‘panel’ consists of the service manager for community care. Care managers present the packages they devise to a senior care manager (called an assistant service manager) who then checks it with the service manager, initially usually by phone, followed by submission of a paper plan. It seemed that most packages were approved verbally in this way. The service manager described her involvement as primarily a procedural device to ensure good budget management, including viring (transferring limited amounts of money) between budgets to allow more flexibility in care planning, and a mechanism for identifying good practice.

Community Mental Health Team (CMHT)

7.7 The community mental health team was set up about four years ago. It was funded jointly by health and social work in a ratio of 60:40. The team manager has a nursing background while the assistant team manager came from social work. The team includes CPNs, Social Workers and OTs. The team also has its own home help service and two part-time home support and day-care workers (funded by the Scottish Executive through the Mental Illness Specific Grant). Initially CPNs, social workers and OTs all brought in their own cultures and ways of working. A decision was taken to agree on one consistent system, which would meet the requirements of each discipline, clients and the respective departments. Generally this seems to have worked well. There was a clear feeling of the team working together.

7.8 Referrals to the team undergo what was referred to as a “gateway” assessment, to ensure they are appropriate. The team’s remit is quite clear: it works with people who have complex and enduring mental health problems. Referrals of people with mild depression arising from poor social conditions were not seen as appropriate. Similarly, people with mental health problems arising out of drug or alcohol abuse were referred to the drug and alcohol teams for initial assessment.

7.9 A full assessment takes six weeks and is a joint process with input from all disciplines including housing (see below). Initially one worker is allocated to take responsibility for the assessment and she collects all the necessary information. Depending on perceived complexity, a case may be allocated initially to a case manager (here the terms ‘case manager’ and ‘care manager’ seemed to be used interchangeably) or a keyworker. Keyworkers are not professionally qualified and generally deal with simpler cases.

7.10 On completion of the assessment, the case is taken back to an allocation meeting consisting of the assistant service manager from social work, a senior OT, a senior nurse, a consultant psychiatrist and an associate specialist. This meeting allocates a worker to be responsible for providing on-going support to the user. Again the complexity of the case
is taken into account here. A situation which had initially appeared complex but after full assessment proved more straightforward could be ‘downgraded’ from a care managed case to a keyworked case (which could continue to be managed by the same worker). Cases could also be transferred the other way from keyworker to case manager. If a keyworker had built up a good relationship with a user but the case proved fairly complex, a case manager might be allocated to support the keyworker in managing it. A simple replacement of the keyworker by a case manager was seen to be potentially disruptive and not always in the best interests of the service user.

7.11 The question of possible territorial rivalries was explored. The team managers reported that all territorial issues had been resolved - health and social work policies were implemented “in a way that worked best for the team”. There had been some initial difficulties with a perception that welfare benefits and housing matters were the only appropriate issues for social work, while health staff dealt with medical problems. Joint training and team building were said to have overcome these problems.

7.12 However, one care manager from the team, while generally positive about the opportunities for joint working, believed that decisions taken at a higher level often impacted on the team’s work. He was particularly critical of a decision apparently taken within the health board that clients being care managed should automatically be placed on the care programme approach (CPA). It was reported that this decision was made to ensure that resources allocated to the team, presumably for the CPA, were not removed due to low numbers. The care manager regarded CPA as a much more ‘controlling’ approach, requiring a level of surveillance that was inappropriate for some users who would nevertheless benefit from care management. Another policy made at a higher level which impacted on the team was that care managers could be social workers, CPNs or senior OTs but could not be staff nurses.

7.13 When asked about creative approaches to care management, the care manager said that innovative thinking was encouraged but creative solutions could only be devised within the limited resources available.

7.14 The average caseload in the team was about 20 but only 10 of these were likely to be care management cases. The other 10 might be keyworked cases or some ‘service’ cases; for instance, care managers might offer some psychotherapy or cognitive therapy. The caseload of 40-45 intensive cases proposed in the Joint Future Report was, again, regarded as too high.

**Housing Links**

7.15 We met with a senior OT who sat on a housing panel and a senior housing officer who had formerly been attached to the CMHT. Although the post attached to the CMHT was currently vacant, it was regarded as having been a success and the acting service manager (community care) reported that the authority would like to replicate the arrangement across other specialist teams.
When the housing officer post in the CMHT was set up, it was seen as unique in Scotland. The post had been funded through resource transfer money. It had taken some time to integrate into the assessment process but the post-holder had been able to link with housing agencies, including the local authority’s own housing department, to persuade providers to give priority to those with care needs.

When the post was first set up, there had been some resistance to allowing a housing professional access to personal information about clients; personal familiarity and recognition of the part that housing professionals had to play in care management had overcome such problems. The housing officer had sat in on allocation meetings and thus became involved even before specific housing issues had been identified. It also meant he had been able to build up his knowledge of mental health issues.

The housing officer received about 800 referrals in the first two or three years. These covered everything from repairs to housing benefit applications. A considerable amount of work was done trying to help people sustain their tenancies and trying to access better and more appropriate housing for users. A good deal of time had been spent liaising with the local authority housing department and housing associations trying to break down preconceptions about users of mental health services. The post-holder was a point of contact for care managers: if they spotted the first signs that a tenancy was beginning to fail they could approach the housing professional. Great progress was reported in building trust both with users and housing providers and in improving working relations between all parties.

Another initiative introduced by Inverclyde was a Joint Housing Nominations Group for community care clients. A problem had been identified where individual care managers might refer one of their users to a housing association but the latter had no way of determining the relative urgency of cases: outcomes could depend on individual care managers’ tenacity in arguing for their own clients. The Housing Nominations Group was set up to try to determine relative levels of priority.

The group does not have a joint assessment process as such. Users arrive at the Nominations Group by different routes but information from different agencies’ forms is then transferred to the group’s own form. The Nominations Group decide whether a client should be accepted on to the waiting list and the housing department then administer the list.

The group is made up of representatives from social work, housing and the community mental health team and meets for about two hours every month. There is always some social work presence at group meetings – although it is not always the same representative. Until he had left his post, the representative from the CMHT was the housing officer mentioned above. He believed that his clients had an advantage when they reached the group both because a lot of preparatory work had been done on their cases and because the Nominations Group was aware that support would be available to
help users sustain their tenancies. Creating sustainable tenancies was one of the group’s main aims.

7.22 It was felt that although setting up the group had required a lot of work at the early stages, it had helped to break down barriers between housing and community care professionals. Discussions about clients’ needs had helped to clarify each other’s roles and clients’ problems. In some cases it had helped to highlight housing need that could be met through mainstream housing stock. It had been useful in demonstrating to social work and health professionals the difficulties which housing colleagues faced and the limitations within which they had to work.

**Rehabilitation Team**

7.23 Winter Pressures monies has been used to set up a ‘rehab’ team in Inverclyde, consisting of two OTs and a ‘rehab’ assistant. Anyone deemed to have “rehab potential” and who is willing to accept a 6 week programme on coming out of hospital, or to prevent them being admitted to care, is accepted. The team currently has 11 open cases. It offers clients an intensive care programme which gradually reduces over the six weeks. The team have their own home helps who are trained in rehab principles – “enabling rather than doing.” If users still require community care services after the six week period, they are referred to the other community care teams. The main users are stroke patients, frail older people and those with fractures.

**Rapid Assessment Team (RAT)**

7.24 The Rapid Assessment Team (RAT) is based at Inverclyde Hospital, a large modern general hospital which offers services to patients from Inverclyde and beyond. The team is made up of qualified social workers, social work assistants, nurses, physiotherapists, OTs and clerical staff. The RAT is relatively new, having only been in operation since January 2001 but the general perception seemed to be that new ways of working had already developed and barriers were being broken down.

7.25 The team holds daily meetings to discuss caseloads and weekly meetings to review progress. There is also a monthly meeting where one member of the team describes their role. The team’s remit is to ensure that all patients with community care needs receive an early assessment before going home. It means that when referrals are made to community care teams, much of the screening has already been done. Some cases, which require only very short-term social work input, are dealt with directly by the team but others are passed on for a holistic assessment. In complex cases the team may call a case conference and seeks to involve the community social work team from the earliest point.

7.26 One of the reported benefits arising from the team’s work is that medical staff on the wards are clearer about what social workers can offer patients. An increasing respect
for each other’s skills means that it is easier to arrange a ‘good’ discharge. Information is passed on more quickly and territorial boundaries within the team are not fixed in stone. A team member always attends ward rounds on the acute medical receiving wards and, we were told, consultants are now taking a more holistic approach to patient care. The RAT accepts referrals from any professional in the hospital who feels that a discharge will require some support. There is a written list of criteria for referral to the Rapid Assessment Team, the main points being that users are expected to be medically fit within 72 hours and reside within Inverclyde. As the work of the team is becoming more widely known in the hospital, these criteria are being adhered to more strictly by other professionals. Hospital patients from outside Inverclyde sometimes feel they are being offered a lesser service: there is no social work presence in the hospital from North Ayrshire, the other local authority responsible for a significant number of the patients at the hospital. The RAT will assess the needs of users from other local authorities and pass on that assessment but there is no mechanism to allow them to purchase services for these patients.

7.27 In the past there had been difficulties identifying the right professional for a particular task: once identified, it had sometimes been difficult to track down the person. The location of the RAT within the hospital has greatly facilitated the logistics of joint working. The team approach also allows members to cover for one another during holidays and other absences. Under the previous system, if the social worker allocated to a particular ward was on holiday, discharges requiring a social work input could not take place until the social worker returned. The team has provided a level of consistency for ward staff and patients and there is better information available on the type of service which can be provided. It was claimed that occasionally community social workers could look to the RAT to delay discharges to allow packages to be put in place.

7.28 The team can call on the services of home carers from the Home from Hospital team; it may augment any arrangement which was in place before the user went into hospital; it may provide a short-term service to allow community care teams time to put a longer term package in place, or it may provide a service to cover a short term need. The RAT monitors patients for six weeks after they return home: cases are then passed on to a community care team. Team members also liaise closely with the Rapid Response Team (RRT).

Rapid Response Team (RRT)

7.29 The Rapid Response Team is based in the community. It was set up in July 2000 and consists of a community nurse and a home care organiser responsible for the Alert system (community alarms). It accepts referrals from the RAT, GPs or community nurses. The RRT is a crisis intervention team which can offer up to 72 hours of overnight care and other services for up to two weeks. That allows time for community social work teams to carry out a full assessment and is sufficient to ensure that the user is safe within his or her own home. The RRT is currently developing an augmented home care service and provides a full package of care for users with a very high level of dependency. It can
provide rehydration of patients subcutaneously and is considering the feasibility of giving intravenous antibiotics at home. After the two weeks of care, the team will monitor users for a further two weeks. If there is no continuing care management by community teams, then the Home from Hospital service or the home care organiser will continue to monitor the case for a further six weeks.

7.30 The RAT and RRT work closely together and share ideas. Both teams were confident that they had sufficient autonomy to make decisions in partnership with users and carers.

Visits to Service Users

7.31 We visited two carers in their own homes. One was the daughter of a man with dementia. She was involved in her father’s care on a daily basis, although she did not live with him. The other carer was the mother of a woman with MS who has very high support needs and lived with her parents.

7.32 Both carers reported high levels of satisfaction with the help received from their social workers. Each saw their care manager regularly and could telephone her if any problems arose. However, both felt there were some gaps in their current packages of care. This was seen as a lack of resources rather than any lack of effort by the care managers.

7.33 The man with dementia had been offered respite care, overnight respite and day care at a day centre for people with dementia. However, none of these options had proved successful. The user was only 65 and his carers felt he was unhappy being with other people with dementia whose illness was more advanced and who were all considerably older than he was. Apparently he returned from these places more disoriented than before. The only support acceptable to the carers came from the Dementia Care Project which came in for two hours a day, and an extra couple of hours twice a week, to allow the main carer (the interviewee’s mother) to go out shopping. After a recent crisis the care package had been stepped up by an extra 10 hours a week but had since reverted to two hours a day. A recent drugs-related incident in the vicinity had disturbed the user and his wife to the extent that they now wanted to move house. Their daughter reported that the care manager had been very understanding, had helped the family to secure the right forms and fill them in. She also helped with other forms, such as applications for benefits.

7.34 Social work staff had reported that packages of care were set up to allow users and carers to call up help as necessary, i.e. a package of 10 hours a week could be used two hours daily or five hours twice weekly, to suit individual needs. We asked the carer about this facility but it appeared the family was unaware of it: her parents were receiving the same hours of care every day. We checked later that the package had been set up to allow this degree of flexibility and a senior care manager confirmed that it had. It seemed a pity that one of the principal carers seemed to be unaware of this potential benefit.
7.35 This carer’s main complaint concerned insufficient services for younger people with dementia. She felt that sometimes users appeared to be slotted into whatever services were available. However, she reported that she was very happy with the help she and her mother were receiving, and felt that the care manager was doing everything she could to help.

7.36 As indicated above, our second visit was to the mother of a young woman with very high support needs. Her daughter had gone into hospital about five years previously, supposedly for three weeks of respite and physiotherapy, and had ended up staying in various hospitals for about 2 years. Finally, her parents had decided to bring her home and both their and the young woman’s homes had been sold to buy a new house which could be converted for her use. A number of adaptations had been carried out with help from social work and various aids had been provided to enable the daughter to live at home.

7.37 The package of care on offer was quite extensive. Nurses came in on a Monday and Thursday and two home helps came every morning, one to help the woman shower and one to change the bed. Another carer came in once a week to allow the mother to go out for an hour. The GP came in once a month and the care manager called once every two to three weeks and phoned regularly. The carer felt sure that if any problem arose she could contact the care manager who would do her best to solve the problem.

7.38 The carer reported that she was quite satisfied with the care package except for the lack of any physiotherapy for her daughter. Apparently this had been requested repeatedly but because of some unspecified bureaucratic problem within the health board, they had been told it was not available in the community. The care manager had tried to advocate on the user’s behalf, as had the GP, but so far without any success.

7.39 Neither carer could clearly recall their relative being offered a community care assessment and both seemed to confuse the latter with medical assessments. However, both were broadly satisfied with their care packages (with some exceptions in each case). Again neither carer remembered being offered a carers’ assessment but both felt that the short breaks on offer were more than enough. The mother of the woman with MS felt that an hour a week was as long as she felt comfortable being away from her daughter (she had in fact been offered more time). The daughter of the man with dementia said that her mother did not want to spend time away from her husband and felt no one could look after him better than his own family.

Conclusion

7.40 We saw evidence of a significant amount of joint working between health and social work staff in Inverclyde. Integration appeared to be well advanced in many respects. Joint teams were well established and on the whole seemed to be working successfully. Teams had been set up after careful planning and training of staff and progress was being made on recognising and valuing different professionals’
contributions. However, despite good joint working on the ground, one care manager had not been able to access much needed physiotherapy for her client.

7.41 The inclusion of a housing professional in a community mental health team was a genuine innovation. Few other local authorities had given thought to including housing professionals in the assessment process before specific accommodation issues had been identified.

7.42 Care plans have to be presented to seniors and then to the service manager. This sounds like a cumbersome process but in practice approval is usually given over the phone within a day or so. It was reported that a substantial amount of viring between budgets took place, allowing more flexibility in care planning: this was reflected in some of the packages described. The idea that users should be presented with an allocation of care time, which they can use as and when it suits, is innovative: it was unfortunate that the carer we interviewed seemed not to understand, or be aware of, the flexibility on offer.

7.43 Care management appears to be working well in Inverclyde with evidence of good joint working, targeting of people with complex and/or changing needs and individualised care packages all happening to a greater or lesser extent.

CLACKMANNANSHIRE

7.44 Clackmannan is the smallest mainland authority in Scotland, although its population is growing. Demand for community care services from older people is expected to increase over the next ten years (SWSI, 2001). Clackmannan has a mixture of rural areas and small towns and villages, some of which have high levels of deprivation. Social work and housing are combined in a department called Services for People.

7.45 Clackmannan was selected for four main reasons:

- evidence of intensive care management, targeting only people with complex needs
- in their recent Best Value Review of Assessment and Care Management, (Clackmannanshire Council, 2001) the authority claimed to be at the forefront of budgetary devolution in adult care
- a custom-designed IT system for administering assessment and care management
- evidence of a creative approach to developing a range of service providers locally.

7.46 During the visit to Clackmannanshire, discussions were held jointly with a service manager and two team leaders and then with a community care worker on her own. Two service users were visited in their own homes.
General Approach to Care Management

7.47 Clackmannan has 14 care managers, called community care workers, all employed by the authority. Seven are from a social work background, six from an OT background and one from a home care background. They are based in two adult care teams, although three are also located part time with a community mental health team. The adult care teams comprise community care workers (OTs and social workers), mental health officers, social care officers and administrative staff.

7.48 Managers were asked why Clackmannan had decided to follow the ‘task’ as opposed to the ‘role’ model for care managers. In response, it was argued that treating care management as a task allowed social workers to deal with a greater number of cases and to target resources more accurately. Indeed, a reported benefit of being a small authority was that staff became much more adept at multi-tasking and undertook a wide range of activities. The Best Value Review sets out some additional advantages associated with the task approach in Clackmannan: one assessor ensures continuity of service contact; the budget is accessible to the wider population and is not ring fenced for any particular group, and it allows for a prompt response to need. Certainly these arrangements appeared to be working efficiently in Clackmannan. However, as we shall see later, similar advantages – and some additional ones - were claimed in Aberdeenshire for the ‘role’ model.

7.49 It was said that targeting care management only at those with complex or rapidly changing needs enabled the process to be managed more efficiently: only those whose needs were greatest really required a care managed package. This approach meant that people could “dip in and out of care management” depending on their current level of need.

7.50 The service manager and team leaders stated that all referrals were dealt with speedily. New referrals are screened on the day they are received, and priorities for assessment and response are set every day. There are four priority levels with corresponding response times, ranging from one day, for people assessed as being at immediate risk, to 10–20 days for those who do not appear to be at significant risk but whose quality of life could be improved by social work intervention. However the extent to which the authority could maintain its rapid response to referrals and assessed need was a matter of resources. To ensure that only those in greatest need are receiving care management, Clackmannan has a policy of reviewing care management arrangements every 8 weeks. It was claimed that this system had led to a reduction in waiting lists, faster hospital discharges and the ability to cope with a higher number of referrals.

7.51 It was felt that the system in Clackmannan allowed community care workers sufficient time to deal with each complex case. The suggestion in the Joint Future Report that each care manager carry a caseload of 40–45 intensive care management cases was felt to be excessive. Fifteen such cases was seen as more realistic.
Budgets

7.52 Budgets are not delegated to community care workers but to team leaders. However, community care workers can request anything they consider necessary for a package of care and team leaders will consider it and usually approve it. Sometimes further information is requested. Community care workers e-mail proposed packages to team leaders who, apparently, respond quickly - usually on the same day. It was argued that delegated budgets to community care workers would be very difficult to administer, as it was impossible to predict which particular sets of needs any community care worker would come across in a certain period. This could result in some community care workers having overspent budgets, and others under spent.

7.53 The community care worker did not believe that the delegation of budgets to team leaders was particularly significant. Although she did not feel that she controlled the money, she did know about costs and budget management. She was aware when budgets were tight and she had to be more economical. However, on the whole she felt that she was free to put together any package of care she judged appropriate; if she was convinced that any part of the package was essential then it would be approved. A recent example of an item of equipment which had not been approved was a showering chair for a user with MS. This item was to cost £1800 and the community care worker herself had not been convinced that a cheaper solution could not be found.

7.54 There were no absolute fixed cost limits for community based care packages. For a package of care exceeding 20 hours a week, community care workers would expect to negotiate on the user’s behalf. The community care worker reported that any assessment which suggested a package of more than 22 hours’ care would tend to indicate the need to look at residential options.

IT System

7.55 The referral and assessment forms are held on an IT system called Carefirst. It is an OLM system, which includes a financial package, (Care Financials) and holds information about authorisation, expenditure and reviews. It contains details of all people known to social work. Mostly the first contact with the department is by telephone and the duty worker who takes the call can look up the IT system to check whether the person being referred is, or has been, known to the department. If so, the duty worker can access any information held about the individual. Details of calls are then written up by the duty worker and entered on to the system. Carefirst includes several blank screens, or open pages, for free prose descriptions of an individual’s needs and characteristics. There is a checklist of items which workers can refer to when filling out the assessment but this is in the form of an aide-memoire. Most workers also use their own checklists. Assessment data on screen can be quite detailed. Workers write down notes when talking to, or visiting, the user and then enter the details on screen on their return to the office. The provision of laptops had been considered but it was felt that clients might find that off-putting. The community care worker liked the fact that the system was not too
prescriptive. Team leaders reported investing a lot of time checking standards of assessments.

7.56 Once details of the assessment and the proposed package are entered on the system, the cost comes up on screen. It was felt important that workers know the financial implications of these packages. Financial assessments are still held on paper but a scanner is to be purchased which will allow financial assessments to be held on the system as well.

7.57 In previous posts the community care worker had been used to working with paper files. In her opinion the Carefirst system was very useful; for example, when a team leader approved an item of equipment, the system automatically submitted an order for it. This cut down on paperwork and the need to chase up orders and ensured quicker responses. However, there had been times when the system was unexpectedly unavailable – when it had ‘crashed’ - which could make life very difficult, albeit on a short-term basis.

**Creative approaches to service development**

7.58 As noted above, Clackmannan does not offer 24 hour support to people in their own homes: the community care worker pointed out that they did not seek to replicate nursing care at home. Nor will the authority fund more than one hour of housework a day, although it does fund personal care and would pay to have a house ‘cleared’ before a care package began. However, the restriction on help with housework does raise the question of how far the authority’s strict targeting of resources allows for the provision of preventive work or the meeting of ‘lesser’ needs. The community care worker mentioned that ILF monies could be used to allow people to top up the local authority service and provide 24-hour care for themselves. This was only available for those under 65: the authority did not run a direct payments scheme which could have helped those over 65. Only half of people’s Attendance Allowance was taken into account, thus allowing them to top up service provision with ‘private’ help as necessary. The community care worker highlighted some of the local resources which could be used, such as a day centre for disabled adults and courses at the local college.

7.59 It was pointed out that it could be difficult to provide services in a rural authority and that transporting people to resources can be an additional problem, which may not exist in an urban setting. However, the lack of providers forced staff to think creatively. Examples were given of the authority having identified a gap in resources and helping a provider to fill it. For instance, there had been a need for some form of day-care for people with dementia. The social work department had persuaded Alzheimer’s Scotland to set up a day centre and had helped by finding premises.

7.60 Another example was finding an independent provider to employ mental health support workers. These staff worked with individuals with mental health needs on a one to one basis, with the aim of supporting them to lead an ordinary life. The support workers accompany the person on her usual activities, for example, they would not pay a
client’s rent for her, but would go with the client to enable her to do so. They would also accompany people to the pub, football matches or whatever was desired, in order to promote the individual’s natural inclusion within the community. Clackmannan provided an initial three day training programme for staff involved in this project, and give £100,000 per annum to fund the scheme. It was said to have reversed some people’s experience of the ‘revolving door syndrome’ by supporting them within the community and preventing hospital admission.

Joint Working

7.61 Like many authorities, Clackmannan is working on a single joint assessment process. Clackmannan is one of the sites piloting a single shared assessment tool as part of the work being carried out by the Chief Nursing Officer’s group. It is currently negotiating with Forth Valley Health Board to put terminals into the main local hospital to give health staff full access to social work information and to allow health colleagues to add their own information at the referral and assessment stages. However, the authority had not yet reached the point at which it would be able to accept assessments carried out by medical staff without some further social work assessment.

7.62 There is a Community Mental Health Team with attached social workers and a Learning Disability Service has link workers. Both teams are assessing issues jointly and are also working towards a single assessment.

7.63 Clackmannan has a Rapid Response Team, which has access to two providers who are able to put in services at short notice. It was reported that much of the team’s work is about risk management.

7.64 There were regular GP practice liaison meetings in one part of the authority. These seemed to work well although GPs in the more rural areas did not want such formal links with social services. Access to specialist assessments was not seen as a major problem but GPs could sometimes prove a stumbling block where they had made a diagnosis which they felt did not require any further assessment. It was sometimes necessary to remind clients that a referral to a specialist was their right.

Visits to Service Users

7.65 The two service users visited had complex needs and one was still recovering from a stroke. Both reported being perfectly satisfied with the services received. However, one had experienced a significant problem in relation to a home carer but reported that her community care worker had eventually resolved it. We spoke to one family member who said that she was confident that she could contact the community care worker to discuss her mother’s case if necessary and that she too was happy with the service being provided. In one case a range of equipment and aids had been provided as well as homecare and these seemed to be working well. However the user did say that it
had been a process of trial and error to arrive at the correct combination of aids to suit her particular requirements.

**Conclusion**

7.66 Clackmannan is practising intensive care management, targeting people with complex needs. Its IT based system allows for quick and easy access to details of past and present clients, and helps ensure a rapid response both at the point of referral and once needs have been assessed. The authority has innovative plans to allow health staff direct access to its information. The degree of decision making delegated to community care workers seemed less significant to front line staff than might be anticipated, but the small size of the authority was seen as significantly reducing the layers of bureaucracy. It was reported that the authority had a creative approach to service development: it had identified gaps in provision and worked with providers to fill them. Although some of the services on offer appeared to follow fairly traditional lines, there was also evidence of more innovative initiatives such as the mental health support workers.

**ABERDEENSHIRE**

7.67 Aberdeenshire is another very rural authority. It has a healthy economy based around farming, fishing and tourism: indeed it has the lowest level of unemployment in Scotland. The older population is expected to increase by as much as a half in the next 16 years (SWSI, 2001). Social work services are combined with housing in one department. The authority is divided into three areas - North, Central and South Aberdeenshire.

7.68 Aberdeenshire was selected because it was the only local authority whose responses to the initial interviews indicated that it met nearly all the criteria set out for selecting case study areas. Specifically, the data indicated that:

- care management for older and disabled people is a role, not a task
- it is targeted at people with complex needs
- budgets are devolved as far as individual care managers
- there is evidence of joint working in specialist teams
- a significant number of care managers come from a nursing background
- the community dementia teams are using a joint assessment tool; another one is being piloted in a health centre
- there is evidence of creative thinking in drawing up individualised care packages.

7.69 During our visit, we had four separate meetings with professionals: first, with three senior care managers covering, respectively, Central, South and North Aberdeenshire; secondly, a care manager from South Aberdeenshire; thirdly, a representative from both the community mental health team and the community dementia team and, lastly, staff involved in piloting shared use of CarenapE at Inverurie Health Centre. We also visited a service user and his carer at home.
General Approach to Care Management

7.70 There are 83.75 FTE care management posts in Aberdeenshire: NHS Trusts are the employers in 23.5 cases. Many care managers share a building with OTs and Home Care supervisors. In North Aberdeenshire, social work staff had just moved into the local health centre to work alongside district nurses and other primary care staff. This arrangement is planned for other parts of the authority although finding suitable accommodation is difficult. Care managers working with older and disabled people are also aligned to GP practices, as discussed below. There are a high number of care manager posts based in multidisciplinary teams - about 52, it was reported. Most staff come from a social work background, although 27 have a nursing background while a couple are OT-trained.

7.71 Aberdeenshire has a mixture of the role and task models of care management but it is unusual. In other authorities with a mix, the task model is followed in 'generic' community care teams, ie: usually in work with older and disabled people, while the role model is confined to specialist or multi-disciplinary teams, but in Aberdeenshire it is the opposite. Here, care managers in care management teams are responsible for services to older and disabled people. For them, care management is a role and they do nothing else. Care managers in multi disciplinary teams follow the task model. The community dementia teams have care managers employed by the NHS, while care managers in other multi-disciplinary teams – mental health, substance misuse and learning disability – have care managers employed by the local authority. The latter also has nurses employed by the NHS but they are not care managers.

7.72 Care management in Aberdeenshire has recently been re-organised along functional lines. A senior manager has been appointed to be responsible for care management for older and disabled people across the authority. It was previously organised geographically, and for this reason there are some variations in care management practice between its three regions (which still exist). However these are fairly minor and the plan is to bring arrangements in the three areas closer together.

7.73 Senior care managers reported that the Aberdeenshire model of care management is that set out in the 1989 White Paper. We were struck by the fact that criteria for care management were clearly set out and that care management was said ‘to start with’ these criteria. These identify the particular circumstances in which care management is appropriate, and, where this is the case, the level of priority which should be accorded different cases. A high priority for care management is given to people who are unable to stay at home with their existing care arrangements. Medium priority is given to those who have significant difficulties in coping with daily living, who are looked after by a carer where the situation is likely to break down in the near future, and to people who cannot be discharged from hospital unless services are in place. People are not likely to qualify for care management if their needs can be appropriately met by existing Aberdeenshire Council social work services (such as home care or day care) or if another statutory agency has a responsibility to provide care. The care manager interviewed was quite satisfied that the criteria were sufficiently clear to allow her to make decisions about
eligibility without having to refer to senior staff. It should be emphasised that, in having written criteria for care management, Aberdeenshire differs significantly from other authorities, some of which have criteria relating either to urgency of response, level of assessment or service provision, while others have criteria which do not necessarily target those with complex needs.

7.74 As indicated above, care managers for older and disabled people are aligned to GP practices. There is an open referral system – anyone can make referrals at any time – and because these are made direct to the care manager, there is no need for allocation meetings. There are benefits to both referrers and users from this system: cases are picked up quickly and urgent cases can be visited on the day they were referred. The longest ‘follow-up’ time for any case is five days. There can be some drawbacks for care managers in terms of caseload management, because up to seven or eight referrals can be picked up from one practice meeting. However, it was pointed out that some of these are likely to be relatively straightforward cases which the care manager would refer on to the home care supervisor or meals on wheels as appropriate. The organisational areas of North, South and Central Aberdeenshire cut across GP practices. Therefore a practice may have more than one allocated care manager. However, care managers on the ground deal with any problems by making sure that they keep in close contact and, it was reported, are able to pass cases between one another without fuss. The care manager interviewed during the first part of the study worked part time and had 14 cases at assessment stage and 37 which she monitored and reviewed.

7.75 The care manager interviewed during the study visit reported that she made an effort to keep assessment a 'low-key' process. She did not complete forms in the client’s home: assessments took the form of a ‘chat’ where she used her professional skills to tease out any underlying difficulties. This approach was echoed by one of the seniors who explained that, while care managers do not provide services, in many cases counselling is a valid and important part of the assessment process. The role model of care management has been criticised for its apparent neglect of ‘traditional’ or therapeutic social work skills – listening, counselling and supporting clients. This does not appear to be the case in Aberdeenshire, although the ability to exercise these skills was not seen as unique to social workers.

Budgets

7.76 Budgets in Aberdeenshire are devolved down to care managers: again, this is unique in Scotland. There are minor differences in the arrangements in each area. In general, care managers have authority to spend up to £150 per person per week to keep someone out of residential care, and up to £230 to prevent admission to a nursing home. Within those limits, they have complete freedom. In Central Aberdeenshire, any package above £230 has to be approved by the service manager responsible for care management across the authority (the senior care manager has no access to additional funds). In South Aberdeenshire, the same arrangements apply, but care managers discuss cases with their senior if the cost is going to exceed £150 per week. In North Aberdeenshire, care
managers can put together any package costing up to £245 to avoid nursing home admission. If a package is going to cost more, they put an argument for the case to the service manager. Requests are rarely turned down. The reason for referring to seniors is to alert the latter to a case which is becoming more complex.

7.77 When expenditure above £230 a week is approved, this is usually on a short-term basis only. If a user needs a higher level of care in the long term, this would be ‘outside the local authority limits’. It would then become necessary to consider residential or nursing home care. However, the authority does support a small number of people in the community at a higher level on an on-going basis. These would either be individuals who had intensive packages of care in place prior to the introduction of charging policies, or where there are ‘particular reasons’ to support them at home, as in the case of disabled parents or people with terminal illness.

7.78 The allocation of nursing and residential home places varies somewhat between different areas. In the North of the authority, care managers have a devolved budget but operate it on a locality basis. They decide as a group how the money will be spent and which users are going to be funded for places. Sometimes this involves pooling individual budgets: for example, if one care manager’s budget is over-spent and it is decided her client should have a place, then another care manager whose budget is under spent may ‘top up’ as required. In South Aberdeenshire, as well as completing the usual assessment for long-term care, care managers also carry out a dependency assessment which gives the individual an overall dependency rating or score. The team has a shared budget for residential and nursing home places and each case is given a priority, based on these dependency scores. In contrast, Central uses a panel system. This allows for a broader view of priorities across the area and is perceived as providing a fair system for users. However, these benefits are increasingly seen as outweighed by other drawbacks, to the extent that Central is considering moving to a locality based system.

7.79 It is thought that the panel is disempowering of care managers, who simply put forward a name and a written case and are not involved in making decisions. Because the managers considering this information do not know individual clients, they are not necessarily in the best position to make decisions. In the North, where care managers make joint decisions about allocation of residential and nursing home placements, the process was apparently experienced as both empowering and mutually supportive. On the other hand, it is recognised by seniors that some decisions might hinge on the tenacity or persuasiveness with which individual care managers argue the case for their particular clients. In South Aberdeenshire, where the dependency rating is used to allocate places, a clear and consistent basis exists for shared decision making. In addition, the dependency score gives a clear basis for explaining to carers or GPs why one person has been funded over another. Senior care managers are currently considering the advantages and disadvantages of the three systems with a view to developing arrangements which maximise the benefits of each.

7.80 We discussed the perceived advantages of devolving budgets as far as individual care managers. It was argued that holding their own budgets empowered care managers
and enabled them to feel more in control of their work. This system is seen as much quicker than others: care managers can quickly go ahead and make the arrangements which the assessment has shown are needed. It was also reported that care managers look more closely at service quality and contract compliance, because the money is coming out of their budget.

Creative Approaches to Service Development

7.81 Both the care manager and senior care managers identified difficulties finding creative responses to need within a very rural and sparsely populated environment. Problems are being experienced recruiting and retaining staff, particularly home carers, and it is difficult to set up community resources when users might be scattered over a wide geographical area. Availability of transport is a related problem. Seniors recalled that when care management was first introduced, there had been high hopes of being able to purchase the services of neighbours and friends to support individual users. However because the authority was ‘bound up in bureaucracy’, such as health and safety regulations and employee rights, this had proved difficult. Nevertheless, these issues have been addressed in certain cases by persuading a local voluntary agency to act as an umbrella employing agency, taking on an individual to support a particular user. Such arrangements could take a while to set up, however.

7.82 Despite these reported difficulties, there was evidence of imaginative responses to individual need. One senior commented “I genuinely believe that people always have some choice”. There is a range of providers available; for example, there are various day care options and people can choose when and how often they attend and what they do there. An aromatherapy class had been set up in a residential home for both residents and older people living in the community. The project was regarded as a success partly because one of the course members, who had been finding it increasingly difficult to live independently, felt able to decide to move into the home because she had already made some friends there. Another example concerned a young man with very high support needs who had been in a motorcycle accident, whose care package involved ten different service providers. It was evident that planning to support this young man at home, with the help of ILF monies, was a considerable achievement.

IT System

7.83 When drawing up care packages, care managers input information onto a computer software package called Carefirst (also used in Clackmannan). Finance staff input a user’s financial assessment and the system combines that with the costs of the care plan to produce a bill. Previously there had been a paper system, where forms were passed to the finance department and it kept track of information and activities. When the new system was introduced, the finance department was apparently worried about the ability and meticulousness of care managers in adhering to procedures (particularly those in multi-disciplinary teams who had other tasks to perform). However, these concerns
had not been realised. The care manager reported that the financial information she was given was sufficiently detailed and up-to-date to allow her to keep a close eye on her budget.

7.84 One area identified as requiring some further thought was the need for local authority and health IT systems to be more closely linked. However some progress has been made on this in relation to use of CarenapE, as explained below.

Joint Working

7.85 There is a great deal of joint working going on in Aberdeenshire. We interviewed members of the CMHT, the community dementia team and two staff working on the single shared assessment pilot, namely, a rehabilitation nurse and a social worker appointed as a part-time development worker to the project.

7.86 Two community dementia teams, one in South and one in Central, were set up eight years ago. The Central team (which has two office bases) comprises two full time social workers and one full time G grade nurse. The other has one full time social worker and a half time G grade nurse. A home care supervisor (who also happens to be a qualified nurse) works between the two teams. They also have their own home care team and access to ‘night settlers’ employed by the NHS. The local consultant psychiatrist works very closely with the team and, we were told, is very supportive of it. Local GPs are well aware of the team’s work and readily refer users. Staff in the team carry out assessments using a joint assessment tool and each has authority to arrange care packages. They also offer some specialist services. The team appears to be working well together with good support from the local consultant.

7.87 The care management service within the community mental health service is confined to social work. There is a social worker/ care manager attached to each of the three consultants who serve the GP practices within Central Aberdeenshire. Referrals are picked up at weekly multi-disciplinary team meetings held at the Royal Cornhill Hospital in Aberdeen. The senior social worker manages only the council staff. A working group was recently set up consisting of social work, OT and nursing staff and a joint assessment tool was designed. A pilot was to be tried within one team but the idea met with great resistance from the consultants and this has not progressed to date.

7.88 The team involved in piloting a single shared assessment tool at Inverurie Health Centre consists of a Home Care supervisor, a district nurse, an OT, a care manager, a ‘rehab’ nurse and, as mentioned above, a part time development worker. A small group had been set up to look at using CarenapE as a single shared tool prior to the publication of the Joint Future Report. Indeed, the ethos for the project came from ‘Modernising Community Care’. Some research had been carried out to look at different tools, and the team had decided to pilot CarenapE. It was selected because it appeared simple, contains basic information, including medical information, details users’ and carers’ perceived needs and because it quickly identifies if a user has no need, a met need or an unmet need. CarenapE also includes the individual’s care plan. The whole form can be skimmed
through quickly and there is a summary at the end, which can be shared with colleagues and is placed in GP notes.

7.89 Any member of the Inverurie team can complete CarenapE. If the assessor identifies a lot of need in one area, for example occupational therapy, she copies the CarenapE form to the OT, who can then carry out a specialist assessment as required without having to repeat the whole process. Likewise, when a Home Care Supervisor receives a copy of CarenapE, she only needs to carry out a financial assessment. Other practitioners keep their own assessments (ie: the OT’s assessment would not be attached to the CarenapE assessment).

7.90 Software is currently being developed in-house which will allow social work and health staff to exchange and share CarenapE assessments by PC (although it will not extend to sharing other information). Personal computers have been bought for this purpose although some technical issues remain to be resolved. Again, our information suggests that this development is unique in Scotland, although there are plans for similar developments in Clackmannan. Once the whole process is computerised, the fact that a follow up assessment has taken place, and its outcome, will be recorded.

7.91 Since the beginning of April 2001, the pilot project has used CarenapE with 15 people who have complex needs. It was tested with 20 people the previous year. Some individuals with complex needs are not seen as suitable for CarenapE; for example, if they do not think they have needs, or there is an element of dementia, since users have to consent to the sharing of information. Staff reported that CarenapE is cumbersome and can take a long time to carry out, but as the pilot progresses it is anticipated that assessments may be completed more speedily. The benefits claimed for CarenapE included that it enables the assessment to be done in partnership with users; it allows the assessor to set out the views of both user and carer which it was argued, helps limit possible areas of conflict, and it records unmet needs. Although those respondents were not able to say how these benefits compared with using the community care assessment form used elsewhere in Aberdeenshire, it was said that staff using CarenapE were in favour of retaining it. It was claimed that CarenapE creates “a dialogue between professionals” but the point was also made that this pilot is taking place in an area with a history of good joint working. It was recognised that rolling it out to other areas where relationships were less good would be more difficult. Three more pilots are planned, and the authority aims to have a single shared tool in place across Aberdeenshire before the end of 2001.

7.92 At the moment, people having a CarenapE assessment also have standard community care assessments. The plan is that CarenapE – or whichever single tool is finally adopted – will supersede this. The final decision about which shared tool to use will be taken jointly by social work and health.

7.93 Aberdeenshire had applied to be part of the pilot studies being conducted by the CNO’s group but had later withdrawn due to a change in the latter’s timetable. Some concern was expressed about how use of a single shared assessment tool demanded by
the Joint Future Group, and supported by the CNO, will mesh with the Resource Utilisation Tool also proposed by the CNO.

7.94 A number of respondents commented that the impetus for joint working must come from top down and bottom up. It was reported that senior managers in both health and social work are committed to working together, and that strategic decisions were taken by joint committees. There is a joint Community Care Committee and a Joint Future Committee, set up in April 2001, with representatives from social work, health board and Trusts. The appointment of a development worker to drive forward joint working had helped to identify a knowledge gap among social work and health practitioners about policy developments. This was a ‘gap’ between what managers wanted to push forward as an agenda, and what practitioners were aware of in terms of national policy demands. Work had taken place to explain to practitioners exactly what the Scottish Executive expected in terms of further joint working; this was seen as helping motivate front line staff to push forward their efforts in that direction.

7.95 One senior care manager commented that co-locating staff in the same premises made a significant difference to joint working. She saw this arrangement as giving clarity in complex situations. However, another respondent believed that, while useful, co-location of workers was not vital. In her view, good joint working was taking place where staff were in separate premises. However, she added that joint working also takes time to evolve and not enough attention is always given to team building. There is no joint training as yet in Aberdeenshire, although there are various joint forums for discussion and information exchange. For example, six-weekly meetings, involving social work management, care managers, an OT, GP and district nurse, take place at Inverurie Health Centre to discuss new developments and exchange information. The LHCC has monthly meetings with a speaker to which social work staff have an open invitation.

Visits to Service Users

7.96 We visited a user and his wife in their own home. The user had very high support needs following a stroke, along with some other health problems. His care package included daily visits by home carers, crossroads staff twice weekly, weekly day care provision, a stroke club, residential respite on a three monthly basis, and regular help from family and friends. The latter included a weekly outing for morning coffee as well as a visit to a local pub one evening a week. Their care manager had arranged a holiday for the couple to an ex-servicemen’s home in another authority.

7.97 Like most users, this gentleman reported that he was very satisfied with his care package. Both he and his wife were very pleased with their principal home carer. However the user did not enjoy having respite care in a local residential home: this he found boring, but he realised that his wife appreciated the break. She felt that the package met her husband’s needs but she was still a little dissatisfied with her situation. She could not say what extra services she needed: it is often difficult for families to identify forms of support which do not appear to be currently available. Although she expressed
gratitude for the help provided arranging the holiday, she would greatly have preferred a less institutionalised and more ordinary setting. This may have been difficult to arrange however, given her husband’s needs for a wide range of aids and equipment. The carer was pleased with the services of her care manager, whom she knew by name. She remembered her husband’s community care assessment taking place and her own carer’s assessment (again, no other carer we interviewed seemed to be aware of the latter) and seemed to have a good general grasp of the way in which care management worked. No doubt this was partly because she was a very able person, but also reflects good information-giving on the part of the care manager. Overall it seemed that this lady was unhappy about, in her words, “feeling trapped” by her situation, rather than about the support provided.

Conclusion

7.98 Of our five case study visits, the version of care management practised in Aberdeenshire most closely matched both the model set out in the 1993 White Paper and the recommendations of the Joint Future Group Report. The authority has set out clear criteria for care management, enabling it to be targeted at those with complex or changing needs. The lack of convoluted allocations procedures or meetings means that referrals can be responded to quickly, although this can also create some pressure on care managers, at least in the short term. Budgets are devolved to care managers and they have the information and systems in place to manage them effectively. Although there is no direct evidence from this study to ‘prove’ it, staff in Aberdeenshire believe that the devolved budgets facilitated imaginative care planning, tailored to individual needs. Joint working appears to be working well in most areas, and Aberdeenshire is relatively well advanced in the use of single shared assessment tools and its related plans to develop compatible IT systems for social work and health agencies. However, the experience of the CMHT reinforces the point that, in order to be effective, joint working has to be accepted by staff at all levels. Finally, in Aberdeenshire there was a sense of not only the users but also the staff being empowered by care management.

SUMMARY OF THE FIVE CASE STUDIES

7.99 Chapters 6 and 7 were grouped to reflect an obvious difference between the first two - Scottish Borders and Moray - and the other three - Inverclyde, Clackmannan and Aberdeenshire: the former offer care management to all community care clients, whereas the latter target only those with complex needs. In these three authorities, care managers do not deal with simple cases; these are routed to home care, OTs or other staff as appropriate, allowing care managers, who are all qualified practitioners, to concentrate on clients with complex or frequently or rapidly changing needs.

7.100 However, both Borders and Moray also differentiate between clients with different levels of need. The intention is that this should be reflected in the nature and level of care management offered to different clients. However there was some evidence that this policy was not systematically applied in Borders, with some workers carrying
out full assessments of all clients, and difficulties being experienced carrying out reviews. Moray has a system of ‘pooling’ stable cases for review purposes which appeared to work well. However there was also some evidence that care managers in both authorities had high caseloads.

7.101 A significant difference between Moray and Borders related to the use of unqualified staff. In the latter area, unqualified staff do not take on complex cases. If a case assigned to an unqualified worker turned out to be more complex, it would be passed on to a qualified care manager. In Moray the policy was that unqualified staff can carry complex cases with support from qualified seniors, but the latter reported that in practice this was the source of some difficulty. In addition, qualified staff also deal with simple cases.

7.102 It was striking that of the five authorities selected for case study visits, only one was (mainly) an urban locality. The rural authorities faced particular challenges in organising care management, including scarcity of resources, transport problems and potential isolation of users. However, these factors had forced them to be resourceful and creative, as reflected in a number of initiatives.

7.103 Aberdeenshire was unique in having delegated budgets to care manager level, thus giving individual staff a high level of autonomy in purchasing decisions. This was reflected in innovative and complex packages sustaining people with high support needs at home but also in a sense of empowerment among staff. Having access to sound financial information and clear spending guidelines were key to good budget control by care managers.

7.104 Inverclyde and Clackmannan are both small authorities. Here decision making, although not in the hands of individual care managers, was seen to be quick, fair and could be easily influenced by the latter’s views. In both cases, staff pointed out that the size of the authority made for close working relationships between practitioners and managers, and between local authority staff and those in other agencies.

7.105 Borders has a Eligibility Panel to approve most community care packages, and Moray has a similar arrangement for residential placements and large packages of care. Staff in both areas identified certain benefits from these arrangements – ensuring equity across the authority, better budget management, and care plans which adhere to eligibility criteria. On the other hand, the panel system sometimes led to delays in implementing care packages. In Aberdeenshire, where different areas had experience of different systems, it was felt that panels were disempowering of care managers and that panel members were not best placed to take decisions about individual clients whom they did not know. Other approaches in Aberdeenshire for allocating residential and nursing home places included care managers making decisions on the basis of dependency scores, and pooling their individual budgets.

7.106 Each of the authorities was undertaking some level of joint working. Staff stressed that this could only be successful where there was support from “the top down
and the bottom up”. In the Scottish Borders, the partnership approach and the revised joint assessment tool were about to be implemented across the authority. In Moray, the joint assessment tool from the Forres project was already in use by social workers throughout the rest of the area and the joint working initiative due to be extended shortly. Inverclyde had many examples of joint working and use of joint assessment tools, although it was not clear what plans there were to extend joint working to generic care management. However, this authority is one of the few in Scotland which has formally incorporated housing professionals within assessment and care management. Clackmannan is helping develop a joint assessment tool as part of the CNO pilot and has a CMHT and a rapid response team. Aberdeenshire also has good examples of joint working - the community dementia teams and the Inverurie pilot project. However, the CMHT had experienced some difficulties with inter-agency collaboration.

7.107 With regard to IT systems, Carefirst was highly approved by its users. Clackmannan’s plans to allow health staff to directly input their assessments for social work clients seemed genuinely innovative and forward thinking. Moray also had plans to link the social work IT system to health and to allow the public to contact the social work department directly at any time, while Aberdeenshire had purchased computers to allow for joint working on CarenapE.

7.108 Borders was one of the few authorities in Scotland to organise joint training, specific to care management, on an ongoing basis – and to have it independently evaluated. Staff reported that this had promoted a greater understanding of others’ roles.

7.109 As mentioned in Chapter 7, only Aberdeenshire met most of the criteria identified for selecting good practice case studies. However, each of the authorities visited has developed a system of care management which staff felt adequately met the needs of clients in their area.
CHAPTER EIGHT: CONCLUSIONS AND IMPLICATIONS FOR POLICY AND PRACTICE

INTRODUCTION

8.1 Previous chapters have presented the findings of the telephone survey and the case study visits. In this chapter, these findings are brought together to draw out the main conclusions of the research. These are set out according to the study’s initial objectives, although there is some overlap between them. The last part of the chapter considers the broad implications for future policy and practice in relation to care management.

CONCLUSIONS RELATING TO STUDY AIMS

1. To identify local authority social work departments’ policies on the use of care management

8.2 One of the main findings of this research, although it is neither new nor surprising, is that authorities reported a very diverse range of policies surrounding care management. There seem to be three reasons for this apparent diversity:

- inconsistent use of terminology between, and possibly within, authorities
- differences in policy and practice between authorities
- confusion and lack of clarity about certain aspects of care management.

These are separate points but they impact on each other. The terminology surrounding care management is used very differently across Scotland (and beyond – see Manthorpe, 1999). It is very important to be aware that terminology can mask differentiation in policy; conversely, polices and practice which are much the same may be presented quite differently. Perhaps the most critical of these is the term ‘care management’ itself.

8.3 Some authorities say they only ‘care manage’ people with complex needs; others ‘care manage’ all their community care clients. However, there was some evidence of different policy and practice among those who claim to only care manage people with complex needs. For example, a service manager from one such authority also commented that the decision about whom to care manage was not always a ‘pure’ one and could depend on current availability of resources and staff skills. Again, authorities which ‘care manage’ all their clients still differentiate, to varying degrees, between those with different levels of need, the policy being to adapt the process accordingly, for example, by doing simpler assessments, less intense monitoring, less frequent reviews. However, that policy may not always be translated into practice consistently: for example, as identified in previous chapters, professionals may carry out full assessments of all clients in the expectation that the information may come in useful later, or monitor some cases more frequently or intensively than is perhaps necessary. At the same time, some care
managers commented that the level of assessment or review expected by their authority was not always appropriate to the complexity (or otherwise) of the case.

8.4 There was also evidence of confusion and lack of clarity about certain aspects of care management. This can be illustrated by the responses of some service managers, when asked if their authority was using single shared assessment tools. Many reported that they were, but this included arrangements whereby different disciplines in local authority community care teams used the same form, or where care managers asked health colleagues to fill in a medical section on a local authority assessment form, or they informed health colleagues about the results of completed assessments. Some service managers commented that care management policies within their authority required some clarification, while several care managers reported that their role had not been clearly defined.

8.5 These findings all suggest that a clearer differentiation between complex and more straightforward cases would be helpful, matched by a clearly differentiated process for each, with different terminology used to describe these processes (as discussed below).

8.6 Only one authority was using the “role” model of care management; in 21, it was a “task”, while ten authorities reported a mixture of “role” and “task”. A number of arguments were made for and against each approach. Fears have been expressed elsewhere that the “role” model robs social workers of their traditional listening and counselling activities. These are an important part of assessment in complex cases which, this research shows, are not incompatible with the role model.

8.7 Most authorities encouraged some degree of specialism by user group, often using the role model in specialist or multi-disciplinary teams. People with learning disabilities and users of mental health services were the groups most often served by such teams. Although it could be argued that care management skills are transferable between user groups, many care managers believed that knowledge of particular user groups was important.

8.8 All authorities had, or were developing polices for joint working: there was a mixed picture here with some authorities much further advanced than others. Six per cent of care managers were employed by NHS Trusts, 5 per cent were based in GP practices, although many more were linked to GPs, and 11 per cent were located in hospitals. About nine per cent of care managers were OT trained and a slightly smaller proportion, nurse-trained. It was reported that 310, or 16 per cent, of care management posts were located in multi-disciplinary teams, although this is almost certainly an under-estimate. Only five authorities did not have any such attachments. Twelve authorities accepted health colleagues’ assessments, although this was often confined to simple cases or particular projects. Fifteen authorities were piloting or developing single shared assessment tools, or using them within particular teams. One was about to launch a single shared tool for all user groups across the authority. Overall then there was evidence that considerable progress had been made towards closer collaboration with health colleagues.
8.9 In contrast, the involvement of housing colleagues in assessment and care management was generally very weak. However there were exceptions, as mentioned below.

8.10 There was widespread agreement that multidisciplinary work is key to success in care management. Where it was working well, this was identified as a major strength and where it was more problematic, this was a considerable barrier.

8.11 The findings underline the importance of a sound infrastructure for care management, in terms of IT, financial information, accounting systems and budgetary arrangements. A few authorities had plans to develop IT systems which would be compatible with those used by health colleagues. The ability to share and exchange information in this way would obviously be a huge step forward in joint working and the delivery of a seamless service to users.

8.12 Most care managers and service managers identified lack of resources and funding as the most problematic aspects of care management. This was cited as the main reason why authorities were not able to support more people with complex needs at home.

2. To identify how care management operates in practice in each local authority

8.13 Where all cases were care managed, care managers tended to have heavy workloads. Care managers had between 5 and 117 care managed cases each, with a mean of 34. Although this included some ‘open passive’ cases, about half the sample also had non care-managed cases. There was unanimous feeling among care managers and service managers that the Joint Future Group’s recommendation that care managers should each hold between 40 and 45 intensive cases was unrealistic and would jeopardise good practice. This point is taken up again in the final section of this chapter.

8.14 There was some evidence that screening procedures were sometimes protracted and cumbersome, for example, with referrals having to wait for an allocation meeting or a team leader’s decision. However in some authorities referrals were allocated on the day they arrived. Some care managers linked to GP practices took all referrals directly and dealt with them the same day. This reduced the number of referrals going to the social work department while also giving users a more rapid response. It could lead to heavy workloads however. The research also suggests that staff do not always differentiate between the different types of decision required when screening referrals. For example, some service managers said that it was too early to decide on the complexity of a case when screening, while others were making decisions about services at this stage.

8.15 Most authorities differentiated between the tasks assigned to qualified and unqualified staff. Generally the latter would assess and care manage only ‘simple’ cases. There were differences of approach if an apparently straightforward case turned out to be more complex, with some authorities passing it in to a qualified worker and others
allowing the original worker to hold on to it, with support from staff. Where there was little or no differentiation in the type of cases going to qualified and unqualified staff, the former could become frustrated at spending some of their time on relatively simple cases, while watching unqualified workers struggle with complex ones. These findings argue for the need for clear differentiation in the deployment of staff.

8.16 The research has shown that some care managers are significantly restricted in their ability to develop flexible and creative care packages to support people with complex and rapidly or frequently changing needs at home. The main barriers were, or were said to be:

- inadequate funding for care management
- lack of devolved budgets to care managers
- insufficient range of choice regarding ways to meet need
- insufficient choice of specific service
- restricted access to providers, such as having to use in-house services first
- lack of transport to resources
- service-led culture within authorities.

Overall then there were considerable constraints on care managers’ decision-making and purchasing powers, and ultimately on choice for users.

8.17 Many care managers differentiated between cases in terms of how and when to monitor and review. There were a number of differences between service managers’ and care managers’ accounts regarding the frequency and form of monitoring and review, and perceptions of where responsibility lay. There are indications that there may have been too much monitoring of some cases and not enough reviews of others: 12 authorities did not review all their care managed cases.

3. To describe the user groups receiving care management

8.18 Many authorities had difficulty supplying accurate data about the total numbers of care managed cases in different user groups. Another important finding to emerge in this area, although again it is not new, is the inconsistency with which data are recorded across Scotland, with figures relating to care management being hard to come by in some authorities. A few did not know how many care managed cases they had.

8.19 Nevertheless, it is clear that a wide range of user groups are currently being offered care management. The largest group were older people, followed by those with physical impairment and then people with dementia. People with learning disabilities and users of mental health services account for a relatively small proportion. A number of other groups were mentioned with very small numbers in each, such as offenders and disabled children, suggesting a wide interpretation, and application, of care management.
8.20 Looking at these figures, it could be argued that a great deal of care management effort is going into smaller groups, such as people with learning disabilities and users of mental health services. There are more specialist staff and multi disciplinary teams working with these groups, and significantly, there are a number of funding sources specific to them. A related point is that there were repeated reports of older people being moved into residential or nursing homes when the cost of supporting them at home became higher than an institutional placement. This begs the question, although this study cannot answer it, of how many frail older people with complex needs are not being supported at home and, thus, how much long-term care management activity with older people is of the intensive kind.

4. To explore the extent to which budgets and spending authority are devolved to care managers and the extent to which they are able to exercise budgetary control

8.21 Although official guidance and previous research stress the importance of devolved budgets in effective care management, only one authority has devolved budgets to care managers. It was argued that this arrangement was empowering to staff, enabling them to feel more in control of their work and made for quicker service delivery. It was also reported that care managers looked more closely at service quality and contract compliance when the money was coming out of their budget.

8.22 Three authorities have devolved the whole care budget to team managers and in 21, part of it. The remaining authorities had no devolved budgets. However it can be argued that it is not essential for care managers to hold their own budgets so long as they have a good degree of autonomy in designing and purchasing care packages. This was the case in some authorities which did not have devolved budgets. Elsewhere however, budgets may have been devolved to team level but the approval process was protracted.

8.23 A number of benefits were reported for Eligibility or Approval Panels. They were said to ensure equity across the authority, better budget management and encourage care managers to submit care plans which adhered to eligibility criteria. However there were also a number of disadvantages. There could be considerable delays in decision-making and thus, in implementing care packages. Care managers could find them disempowering, because once they had put forward a plan, the decision was out of their hands. In addition, panel members were not necessarily the best people to take decisions about individual clients, since they were only guided by written reports and did not know the individual.

8.24 Overall, it seemed that the arguments against panels outweighed those in favour of them. Alternative approaches for allocating residential and nursing home places in one authority included care managers making decisions on the basis of dependency scores, and pooling their individual budgets.
5. To identify examples of good practice, focusing in particular on areas where integrated approaches to assessment and service delivery, including health, housing and social work are being developed

8.25 This report has identified a number of examples of good practice initiatives in multi-disciplinary assessment and service delivery. Few related to housing although there were exceptions:

- the inclusion of a housing professional within a CMHT
- a jointly funded and staffed housing and support team for 16-21 year olds which acted as the assessment and delivery team for that age group
- in one island authority, a social worker employed as an accommodation officer was able to conduct assessments in order to access single services
- one large rural authority had a post jointly funded by social work, housing and health to help develop “housing based solutions to community care needs”.

8.26 There was not time in this study to examine any initiatives in detail but a few were identified during the case study visits, including:

- multi disciplinary community dementia teams in Aberdeenshire
- the joint assessment project at Forres, Moray
- partnership working, and the use of a single shared assessment tool for all user groups, in the Borders
- the Rapid Assessment Team in Inverclyde.

8.27 In addition, many authorities had rapid response teams, joint discharge teams, integrated outreach teams and so on. Those mentioned above are illustrative.

6. To assess the extent to which care managers are currently carrying out intensive care management

8.28 It is difficult to draw firm conclusions about the extent to which intensive care management is being practised. Where service managers did give estimates for the total number of intensive cases within their authorities, their responses showed significant diversity, with half estimating that these cases accounted for less than 40 per cent of all care managed cases, and a quarter estimating they accounted for over 80 per cent. This compares with care managers’ estimates which on average suggest that about two thirds of their care managed cases were intensive.

8.29 However, as discussed above, in some cases data collected from service managers on this point is undermined by responses they gave to other questions. Similarly, twenty one authorities reported that their screening procedures targeted people with complex needs for care management, but it might be more accurate to say they were targeted for complex assessments or particular types of packages. Only one authority reported having written criteria regarding eligibility for care management. Another indication that a lot of
care management was not intensive comes from the fact that most authorities were severely limited in the extent to which they could offer round-the-clock cover to people in their own homes. Similarly, some care managers reported that certain cases would never be closed but these were not all intensive cases.

8.30 Some of the variation in activity between authorities with regard to intensive care management is due, again, to differences in policy and practice, and some of it to differences in terminology. Intensive care management is not well defined in the Joint Future Group Report and a number of authorities were awaiting clarification. Partly for this reason, and partly due to the difficulty of establishing accurate figures about care managed cases generally, half the authorities declined to estimate what proportion of their work might be described in this way. These findings show the need for better definition of the term, the circumstances in which it would be appropriate, the activities it should involve and the staff who should undertake them.

7. To explore current training arrangements and views on the training needs of care managers.

8.31 In most authorities, current training arrangements for care management were very limited, indeed non-existent in some. Yet service managers clearly had high expectations of care managers in terms of skills, knowledge and experience. Assessment and ‘people’ skills were seen as the most important attributes, with knowledge of resources, finance and legislation also being important.

8.32 Eight care managers reported they had received no training in care management. Just under half the care managers had been given some input on aspects of the care management process but this was often several years ago. In 21 authorities, some joint training had taken place. Although they carried responsibility for care management in their authorities, nine service managers had not had any training in it and, overall, they had received less training than care managers.

IMPLICATIONS FOR POLICY AND PRACTICE

8.33 It is not appropriate for this report to make detailed recommendations: instead, this final section will draw out broad implications for policy and practice arising from the findings. The Scottish Executive will need to give careful consideration to the question of how far it should be prescriptive in any future guidance. Authorities rightly value their ability to develop local solutions to local problems, but there is evidence to suggest that clarification is needed in a number of areas. Part of the problem can be traced back to ambiguities in the original guidance and perhaps within the concept of care management itself.
The need for differentiation

8.34 One of the main conclusions of the research is the need for clearer differentiation at a number of levels:

• between simple and complex cases
• between the level of assessment appropriate to different cases
• between the frequency and form of monitoring and review appropriate to different cases
• between the activities of qualified and unqualified staff.

8.35 Various references have already been made to Edwards’ (1996) model of care management. The findings of this research suggest that Edwards’ thesis is very useful in differentiating between administrative, co-ordinating and intensive approaches to helping people. What is less useful is the fact that she called all three of these distinct activities “types of care management”. One way to address current inconsistencies in policy and practice, the potentially misleading use of terminology, and the lack of clarity surrounding some aspects of care management would be to issue guidance distinguishing between three approaches to helping people with community care needs. These are:

• Information and advice-giving and the provision of very simple services, such as bus passes
• Care co-ordination, aimed at people with relatively straightforward and/or stable needs, involving the provision of simple services
• Care management, (or ‘intensive care management’) offered only to people with complex or frequently or rapidly changing needs, requiring complex packages of care and active, on-going support.

8.36 The first of these, which would involve no care manager contact, would be carried out (as of course it already is in many authorities) by duty or reception staff, some of whom may be administrative workers. Care co-ordination could be carried out by unqualified staff with adequate support and supervision from qualified colleagues. Once a package was in place and the situation well settled, these cases could be placed on a review system. However, users would need to be given a name and number to contact if they wanted to, and service providers would have an enhanced role in monitoring.

8.37 Care management would be carried out only by qualified staff. Edwards (1996) suggested the following criteria for triggering what she called intensive care management:
“Where the needs and/or circumstances of the user are complex, high risk and/or volatile, or
Where the care plan
a) is volatile, or
b) requires high-status co-ordination
Where a transfer of responsibility would jeopardise the user’s acceptance of ongoing assistance or rehabilitation”. (Edwards, 1996, p123).

Joint working

8.38 The research has shown that where single shared tools were being used, professionals were positive about the benefits. However, many authorities are still in the early stages of developing or piloting such tools. The targets currently set by the Scottish Executive for having these in place across Scotland – October 2001 for older people and those with dementia, and March 2002 for other groups - are unlikely to be met by more than a handful of authorities. Rather than authorities rushing to adopt or implement tools without proper preparation, it would be sensible to postpone these dates. Clarification of what is meant by a single shared assessment tool - a tool that can be completed by staff from different agencies, for example by either local authority or health, and accepted by others – might also be helpful.

8.39 A number of different organisational arrangements regarding team structure and location of staff were identified in the research. The benefits of attaching care managers to GP surgeries were weighed against the advantages of placing them in multidisciplinary teams. The latter however cannot be easily linked to GPs. It is likely that there needs to be different organisational arrangements for different groups.

8.40 The Scottish Executive may wish to consider ways of encouraging medical professionals to complete and return specialist assessments more promptly than is currently happening in some areas.

8.41 The research shows a need for social work authorities to work more closely with their housing colleagues. Finding ways to involve them more routinely and yet more formally within the assessment process would be beneficial.

Budgetary arrangements

8.42 Authorities may need more encouragement to devolve budgets to care managers. Although various objections to doing so were raised, and a few authorities had experienced difficulties in the past, the provision of good financial information to care managers and sound accounting systems can address these issues. The evidence overall suggested that panels were a less effective means of making purchasing decisions.
8.43 The findings indicate an urgent need to consider allocating more resources to care management. These should be used to develop more round-the-clock care to keep individuals with complex or frequently or rapidly changing needs at home.

**Workloads**

8.44 A number of authorities reported that care managers were carrying heavy workloads. Having about 15 intensive cases was seen as about right. Again, this is a point the Scottish Executive may wish to reconsider in respect of the Joint Future Group Report.

**Recording information**

8.45 With regard to local authorities’ data collection activities, it is worth considering the usefulness of recording care managed cases separately from other community care cases. Similarly, it might be helpful if community care user groups were classified consistently across the country.

**Training needs**

8.46 Finally, a long and diverse list of unmet training needs was identified among care managers. Most often mentioned were law, finance, specific user group issues and care manager role and tasks. The research suggested that training in screening and care planning would also be helpful. Different levels of training are needed to suit differing levels of experience.
REFERENCES


Buglass, D (1993) Assessment and Care Management: A Scottish Overview of Impending Change, Social Work Research Centre, University of Stirling


Clackmannanshire Council Communications Unit, Fair Care: A Best Value Review, Assessment and Care Management, Alloa: Clackmannanshire Council


Davies, B and Challis, D (1986a) Case Management in Community Care, Aldershot: Gower Publishing Company Limited

Davies, B and Challis, D (1986b) Matching Resources to Needs in Community Care, Aldershot: Gower Publishing Company Limited


Lewis, J and Glennerster, H (1996) Implementing the New Community Care, Buckingham: The Open University,


Stalker, K (1994) Implementing Care Management in Scotland: An Overview of Initial Progress *Care in Place: The International Journal of Networks and Community*, 1,2,104-119


ANNEX 1: Interview Schedule for Service Managers (Community Care)

Care management – overview
1. What are the objectives of care management in this authority?

2. How many people from the following user groups are currently being ‘care managed’ across the authority?

- Older people
- people with dementia
- people with mental health problems
- people with learning disabilities
- people with physical impairment
- people with drug and alcohol problems
- people with HIV or AIDS
- other (please specify)

Where an individual falls into more than one category (for example, a person with multiple impairment), please code according to the most significant characteristic, or under “other”.

3. The Scottish Executive plans to redefine care management as ‘intensive care management’ targeted at people with complex or frequently changing needs. How many people currently receiving care management in your authority fall into that category?

4. Do you have designated care managers who do nothing else, or do you have social workers carrying out care management tasks alongside other duties?

5. Are there variations in care management arrangements across the authority? (If so, please explain).

Joint working
6. How many care managers, or staff working as care managers, are there in this authority?
7. How many (if any) are employed by the following agencies?
   • NHS Trusts
   • Local authority housing department
   • Voluntary organisations
   • Other (please specify)

8. How many care managers, or social workers acting as care managers, are based in
   • The social work department
   • Primary care settings
   • Hospitals
   • Voluntary organisations
   • Other (please specify)?

NB: please include care management posts funded by the local authority even if it is not the employer.

9. How many are from
   • a social work background
   • a nursing background
   • a home care background
   • an OT background
   • other backgrounds (please specify)?

10. How many care managers are there in multidisciplinary teams, such as a community mental health team? (if no such teams, go to Q.14)

11. Do these teams have a joint or pooled budget?

12. If so, which agencies are involved?

13. If there is a joint/pooled budget, what is it used for? (eg: spot purchasing, whole service)

14. If no multi-disciplinary teams, how far developed is inter-agency collaboration?
**Devolved budgets**
15. Are there any devolved budgets for use in care management?

16. If so, which budgets are devolved? *(eg: nursing/residential homes budget)*

17. To what level are they devolved?

18. How much of the budget is devolved?

**Screening**
19. Who screens referrals?
   - social workers
   - admin staff
   - health staff
   - no-one
   - other (*please specify*)

20. Briefly, how is screening carried out?

21. What screening tool, if any, is used? *(check this has been sent)*

22. Does screening target people with complex or rapidly changing needs for care management?

23. Briefly, what is the range of possible outcomes of screening?

24. Who supervises screening?

**Assessment**
25. Do the same staff carry out simple and complex assessments?

26. Do the same care managers assess different user groups?

27. Is there a single shared assessment tool for use by different disciplines?

28. If so, for which user groups?

29. What (other) assessment tool(s) are used? *(check these have been sent)*

30. What role do staff employed by the NHS play in assessment?

31. What role do staff employed in the housing department or housing associations play in assessment?
32. How easy is it to access specialist assessments, such as psycho-geriatric assessments?

33. Are all contributions to assessment contained in a single document?

34. Do users have access to independent advocacy?

35. What arrangements are in place to help people from ethnic minority communities become fully involved in the care management process?

36. To what extent is assessment separated from service delivery?

**Monitoring and review**

37. Who is responsible for on-going monitoring of care managed cases?

38. How is this done?

39. Are all packages reviewed?

40. If not, which ones are?

41. How often?

42. What are the aims of review?

43. Are there any differences in monitoring and review arrangements for community based packages, as opposed to residential and nursing home placements?

**Links with other activities**

44. How does care management link into Care Programme arrangements for people with mental health difficulties, including those with dementia?

45. Do people receiving direct payments have a care manager?

46. Are carers routinely offered an assessment of their own needs?

**Training**

47. What skills and knowledge do you think care managers need?

48. What training do care managers have in care management (*from whom? frequency/content*)

49. What training do service managers have in care management? (*from whom? frequency/content*)
50. What training is given to admin staff who are involved in the care management process? (by whom? frequency/content)

51. Is any of this joint training? (if so - with whom?)

52. Are users or carers involved in delivering training?

53. What qualifications, if any, does this training lead to?

54. How effective is the training on offer?

55. Has the training been evaluated?

56. If so, by whom?

57. Would it be possible for you to send us a copy?

58. What unmet training needs do staff have in care management?

**Concluding**

59. What aspects of care management have proved problematic?

60. To what extent are you able to support people with complex needs at home, or to return home?

61. Are there any particular good practice features locally?

62. Is there anything else you would like to add?

*Thank you very much for answering all these questions. We will send you a summary of the findings once the research has been completed.*
ANNEX 2: Interview Schedule for Care Managers

Background
1. What is your professional background?
2. Who is your employer?
3. What is your job title?
4. Where are you based?
   • community care team
   • multi-disciplinary team
   • specialist team
   • other (*please specify*)
5. Which user groups do you work with?
6. How many open care management cases do you have currently? □
7. The Scottish Executive plans to redefine care management as ‘intensive care management’ targeted at people with complex or frequently changing needs. How many of your current cases fall into that category? □
8. Do you carry any cases which do not involve care management?

Screening
9. Are you involved in screening referrals? *(if not, please go to Q 14)*
10. What are the aims of screening?
11. Briefly, can you describe the screening process?
12. What training have you had in screening?
13. How are needs prioritised?

Assessments
14. What assessment tool(s) do you use?
15. How are different professionals’ contributions to assessment co-ordinated?
16. Are assessments shared with other professional groups?
17. What part do users play?
18. What part do carers play?

**Care planning**
19. What criteria are used for allocating services?
20. Do you have a delegated budget for care management?
21. If so, what can you purchase with it?
22. If not, do you have any financial leeway? *(eg: access to other budgets, viring)*
23. Are there cost ceilings for community based care packages?
24. Do you know the unit costs of in-house services?
25. Do you know the unit costs of external services?
26. Are there enough good quality service providers locally to offer users a choice of ways to meet need?
27. Are there enough good quality service providers locally to offer users a choice of specific services? *(eg different providers of short breaks)*
28. Is your access to providers restricted in any way?
29. If so, in what way? *(eg: have to use in-house services first; prescribed list)*
30. How far is it possible to find creative ways of meeting complex/ rapidly changing need ? *(examples)?*
31. Are friends and relatives included in care plans? *(ie: providing care)*
32. Are you able to provide service cover 7 days a week, 24 hours a day?
33. Are you able to provide emergency cover 7 days a week, 24 hours a day?
34. Is there one single care plan?
35. If so, who has a copy of it? *(check user/carer)*
36. If there isn’t a single care plan, how are care plans shared and co-ordinated?
**Monitoring and review**

37. Do you keep in contact with the person once the care package is in place?

38. If so, how frequently?

39. What kind of contact?

40. Who is responsible for on-going monitoring of the package?

41. What happens if frequent amendments are needed to the care plan because of rapidly changing needs? (*example*)

42. Who is responsible for calling and carrying out reviews?

43. How often do reviews take place?

44. What form does the review take? (*set procedure or adapted to individual circumstances*)

45. Who is involved?

46. What is the role of the service user in monitoring and review?

47. What is the carer’s role in monitoring and review?

48. When would you decide to close a case?

**Training**

49. How well did your professional training prepare you for care management?

50. What in-service training have you received in care management?

51. How useful have you found it?

52. Do you have any unmet training needs in this area?

53. How could these best be met?

**Concluding**

54. What aspects of care management have been problematic?

55. What aspects would you say are working well in this authority?
56. Are there any examples of good practice locally?

57. Do you have any suggestions for improving care management?

58. Is there anything else you would like to add?

Thank you very much for answering all these questions. We will send you a summary of the findings once the study has been completed.
ANNEX 3: Information received from local authorities

1. Aberdeen City
   i. The Rapid Response Team
   ii. Agreement to Joint Assessment
   iii. Personal Profile
   iv. Additional Information

2. Aberdeenshire Council
   i. Guidelines for Using Community Care Services in Aberdeenshire: Eligibility Criteria

3. Angus Council
   i. Best Value Review
   ii. Referral And Screening Form
   iii. Assessment of Needs
   iv. CMHT Forms

4. Clackmannanshire Council
   i. Best Value Review – Assessment and Care Management

5. Dumfries and Galloway Council
   i. Eligibility and Priority Framework
   ii. Community Care and Health Programme Update 2001
   iii. Community Care and Care Management Forms

6. East Ayrshire
   i. Integrated Working
   ii. Summary of Factual Information
   iii. Core Information form
   iv. Practice and Procedures Document
   v. Draft Policy Document
   vi. CCA2 Form

7. East Lothian
   i. Carer’s Information Pack
   ii. Assessment and Care Management a step-by-step guide

8. Edinburgh City Council
   i. Best Value Working Group – Assessment and Care Management
   ii. Draft Appraisal Tool

9. Falkirk Council
   i. Assessment Tool
   ii. Review Form
iii. Procedures and Guidance for assessment and care management

10. Fife
i. Review of Services across Community Care
ii. Community Care Services Procedures
iii. Enquiry Form
iv. Initial Assessment Record
v. Care Plan

11. Glasgow City Council
i. Social Work Receiving Services – brief and documentation
ii. Care Programme Procedures
iii. CCETSW Competencies

12. Inverclyde
i. Generic Community Care paperwork
ii. Client record, Assessment and care plan forms used by CMHT
iii. Homecare assessment forms
iv. Self screening questionnaire used in hospital receiving wards
v. SW info sheet used for elderly patients in hospital
vi. Community Rehabilitation Service Information Leaflet

13. Moray Council
i. CCA01 – Guidelines
ii. CCA01-2 – Referral
iii. CCA02-2 – Assessment of Needs
iv. CCA02-2 – Guidelines
v. CCA03 – OT Assessment
vi. CCA07-1 – Carers Needs Assessment
vii. CCA09-3 – Request for Funding Form
viii. CCA11 – Review
ix. CCA12 – Client Refusal of Service
x. CCA13 – Community Alarm Request
xi. CCA13 – Guidelines
xii. CCA14 – Waiting Letter
xiii. CCA15 – Special Rules Qualification
xiv. CCA16 – Daycare Guidelines
xv. CCA16 – Daycare Information Form
xvi. CC Standards Timescale

14. Orkney Islands Council
i. Assessment and Care Management – Guidance and Procedures
ii. Referral / Core Assessment Form
iii. Comprehensive Assessment Form
iv. Accommodation and Access
15. Perth and Kinross
   i. Self Audit Form
   ii. Initial Assessment and Screening Form
   iii. CCA1 – Referral Form
   iv. CCA2 – Assessment of Needs Form
   v. CCAM2QA – Quick Assessment of Needs
   vi. FABC – Financial Assessment
   vii. CCA3 – Requirement for a specialised assessment
   viii. CCA4 – Information/ Assessment of homecare needs
   ix. CCA2(a) – Carer’s Assessment
   x. CCM1 – Service Request
   xi. CCM2 – Care Plan
   xii. Financial Assessment (differs from vi)
   xiii. Contact sheet
   xiv. Assessment and Care Management Guidance

16. Scottish Borders Council
   i. Referral Form
   ii. Assessment, Care Plan and Proposal
   iii. A Review of Assessment and Care Management in Scottish Borders – 10 Options for Change
   iv. Partners in Care: Implementing a Partnership Model of Care Management
   v. Forms

17. Shetland Islands Council
   i. Joint Procedure for referral, Assessment and Review

18. South Ayrshire Council
   i. Assessment and Care Management Policy and Procedures
   ii. Assessment and Care Management Project 1999-2000

19. South Lanarkshire
   i. Screening and Assessment Tools

20. Stirling
   i. Assessment and Care Management – Guidance and Procedures
   ii. Assessment Form
   iii. Re-referral form
   iv. Multi-dimensional assessment of the frail elderly – forms for health and SW
   v. Comprehensive Assessment
   vi. Supplementary assessment
   vii. Care plan
   viii. Review form
   ix. Financial assessment
   x. Financial information
   xi. Contact record